ROLE OF DEPARTMENT OF VETERANS AFFAIRS IN NATIONAL HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

OCTOBER 14 AND NOVEMBER 18, 1993

Printed for the use of the Committee on Veterans' Affairs

Serial No. 103–29

U.S. GOVERNMENT PRINTING OFFICE
76–163 cc WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-045880-3

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ROLE OF DEPARTMENT OF VETERANS AFFAIRS IN NATIONAL HEALTH CARE REFORM

THURSDAY, OCTOBER 14, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 2 p.m., in room 334, Cannon House Office Building, Hon. Roy Rowland (Chairman of the subcommittee), presiding. Present: Representatives Rowland, Kennedy, Long, Edwards of Texas, Clement, Filner, Tejeda, Gutierrez, Kreidler, Brown, Smith, Stump, Bilirakis, Hutchinson, and Buyer. Also present: Representatives Evans, Ridge, Quinn, and Montgomery (ex officio).

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. The subcommittee will come to order.

We are going to have a vote, I am sure, in the next 20 minutes or so, but I think it would serve us well if we get started now and save as much time as we can.

I want to thank our witnesses for juggling their busy schedules to be with us, and particularly to welcome Secretary Brown and Deputy Assistant Secretary Feder, who are both making their first appearances before this subcommittee.

Today's hearing will further the discussion on the VA's role in national health care reform. As many of you will recall, the subcommittee held a far-reaching hearing on this subject in April. We heard from many health care experts, veterans' groups, and the VA health care administrators. Through their testimony, we identified an agenda for shaping a VA role on the national health care reform.

In essence, we articulated a set of principles intended to govern the development of that VA role. These same principles can now serve as a touchstone to assess the Administration's proposal. Chairman Montgomery and I discussed several of these issues with Mrs. Clinton, and I made certain that the principles were brought to her attention following our April hearing.

Based on the most recent briefings we received, the President's plan is to go a great distance towards meeting the goals we articulated. I think it would be helpful, accordingly, to restate those principles briefly. Key among these is the importance of maintaining

the independence and viability of the VA health care system as a provider offering a full range of services. To that end, a second important principle is for all veterans to have access to the VA as an enrollment option and to be offered a continuum of care.

Under the proposed health care plan, the VA will maintain its independence and will be open to all veterans. If a veteran elects to receive care through a VA health care plan, the veteran would have access to a broader and more comprehensive range of services than under current law.

A third principle calls for VA to be able to compete as an enrollment option for all veterans. We are told VA health care will be among the options open to veterans choosing health plans through new health alliances. As a competing health plan, VA must, therefore, position itself to be an attractive, health care option for veterans.

A fourth concern is that any plan maintain the commitment of providing cost-free care to those with the highest priority. The Administration has apparently adopted that policy and would provide that any service-connected and low-income category A veterans who elect VA care would be relieved of cost-sharing obligations imposed on most other citizens.

A fifth concern is that we be assured that the plan would provide adequate funding for VA health care. We are told that the plan will meet this goal through a combination of funding streams, including revenues from employer contributions and Congressional appropriations, and in the case of higher-income veterans, fund medicare reimbursements and insurance premiums.

A plan for VA health care must build on VA's strengths, and thus must maintain VA's role in education and research. We are assured that this principle is fundamental to the plan's architecture.

Finally, the plan must recognize and provide the means for VA to reform itself—through new construction funding and an expansion of community clinics, establishment of a cost accounting system, improved information systems, and structural changes. The planners reportedly have recognized these needs as well.

The Administration has signaled its willingness to be flexible regarding specific outlines of health reform. As the debate unfolds in the ensuing months, however, it will be critical that the Administration not waiver in its commitment to veterans' health care and to the fundamental principles reflected in its plan.

Equally important will be the support of the veterans' community. To their credit, veterans' organizations have closely monitored the evolution of the President's plan, and their views have helped shape its outline.

As I understand it, their meetings with the First Lady and overview of the plan have prompted near-unanimous endorsements. Such support will be critical to final passage of the President's plan.

This morning, we look forward to learning more about the plan as well as laying the foundation for reviewing legislation which will be submitted in the weeks to come.

As the President has indicated, the health care proposal is not being presented as if it is written in stone. Rather, the Administra-

tion expects the Congress to fine-tune its proposal, where necessary. We will certainly review the bill closely to help ensure that the final product has broad support both within the Congress and, more importantly, within the veterans' community.

I commend the Administration and Secretary Brown for their efforts to stand by America's veterans as we tackle health care concerns affecting all of our citizenry.

At this time, I am going to recognize Chris Smith, the ranking minority member, and let me say that each individual will have 5 minutes if they desire to make opening statements, but I hope you won't take the 5 minutes.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. I would like to join you in welcoming Secretary Brown and Judy Feder, who I understand is at the Ways and Means Committee right now, to our subcommittee this afternoon.

Despite the helpful briefings provided to the committee and the subcommittee from Assistant Secretary for Policy and Planning, Vic Raymond, the health care reform bill has generated many questions in our minds. Frankly, how can any plan of this scope, which took over 9 months to complete, not generate a whole host of tough and difficult questions?

I know you are prepared, Mr. Secretary, to give us some firm answers to at least some of the these questions, and I know many more specific questions will arise as we get the actual legislative document which I understand should be tendered sometime next week.

Mr. Chairman, this subcommittee has previously conducted hearings on the impact of national health care reform and the impact it will have on the VA. In April, we released our nine-point agenda which outlined the key components any health care reform plan must embrace. Overall, I am pleased to see that the Nation's commitment to our veterans will not be overlooked by the President's plan.

However, there remain a number of serious concerns which must be addressed concerning the implementation of the President's plan or any other plan that might be enacted by the Congress.

In particular, I am troubled by the Canadian experience and how we may be condemned to repeat that failure. As my colleagues recall, after implementing a national health care plan, the separate veterans health care system in Canada simply withered away. We cannot allow that to happen in the United States from the enactment of any health care plan.

Mr. Chairman, I am also deeply concerned that the President may insist on providing abortion on demand throughout the Department of Veterans Affairs, turning those 171 hospitals and 350 outpatient clinics into abortion mills.

The VA's health care network has been and must continue to be dedicated to the preservation of human life. I believe, as do many members of this committee, that the overwhelming number of Americans, the taxpayers, do not want their money being used to subsidize the demise of unborn children, and that exactly is what abortion is all about, it is the taking of a baby's life.

Mr. Chairman, I agree that we must take action to halt the escalating costs of health care and to guarantee that health insurance is available to all Americans. I also agree that the VA has an important role to play in America's health care delivery network. There are simply several key issues that need to be resolved as we move forward.

Mr. Chairman, I look forward to the testimony of Secretary Brown. He is most welcome by the minority members of this subcommittee as well as the majority, and I yield back to you the balance of my time.

Mr. ROWLAND. The Chairman of the full committee, Mr. Montgomery.

Mr. MONTGOMERY. Mr. Chairman, I would like to welcome the Secretary, and I will submit my remarks for the record because of time. Thank you.

Mr. ROWLAND. Without objection.

[The prepared statement of Chairman Montgomery follows:]

PREPARED STATEMENT OF HON. G.V. (SONNY) MONTGOMERY, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, HOUSE OF REPRESENTATIVES

Mr. Chairman, I just wanted to mention that the President and the First Lady sought the views of veterans' advocates in the Congress and the national veterans' service organizations during the development of the health care reform plan. It was evident from these meetings that they have a genuine concern for the well-being of veterans. Senator Jay Rockefeller and I met twice with Mrs. Clinton and she was very receptive to our ideas. We were very impressed with her knowledge of the VA. She talked about how her father had preferred VA care.

VA had a lot of input into this plan. We were pleased to see the President appoint Jesse Brown to the health care task force headed by Mrs. Clinton. We also were pleased that 33 VA employees were among the health care professionals and experts making up the staff of the task force.

As I understand it, the President's plan maintains the VA as an exclusive option for all veterans. It will expand access to veterans who currently are denied VA services due to inadequate resources. Veterans with service-connected disabilities or low incomes who choose VA as a provider will pay *nothing* for their care, no copayments nor deductibles. Higher income veterans whose conditions are not related to military service will be required to pay a share of the cost of their treatment just like other citizens.

If the President's proposal pertaining to veterans is adopted, veterans should have no real concern about their health care services. And I should point out that the veterans' organizations and military associations have endorsed it.

Mr. ROWLAND. I recognize the ranking member of the full committee, Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

I will do the same. I will just welcome the Secretary here, and I do have a statement for the record, please.

[The prepared statement of Congressman Stump follows:]

PREPARED STATEMENT OF HON. BOB STUMP, RANKING MINORITY MEMBER, COMMITTEE ON VETERANS' AFFAIRS, HOUSE OF REPRESENTATIVES

Thank you Mr. Chairman. I appreciate the opportunity to review for the first time in this Subcommittee, the potential impact of the President's National Health Reform Plan as it relates to veterans.

It is my belief that this Subcommittee's role in designing the future structure of veterans' health care delivery is the most monumental issue facing us this Congress. It is my intention to proceed very cautiously and with great deliberation before recommending any legislation which would change the veterans' health care system.

Most importantly, the veterans of this Nation need to be heard and they must have details of any proposals which come before this Subcommittee. It is my hope

that we will be able to uncover many details of the President's plan today. Until now, we have had broad overviews of what that plan entails. This hearing will provide us the opportunity to explore the President's proposal further and make important determinations as to what it may mean for veterans.

I look forward to the testimony of the Secretary of Veterans Affairs, Jesse Brown and also to the insights of the White House Health Care Task Force as provided by Ms. Judy Feder. I thank them both for being here.

Mr. ROWLAND. Are there any members who desire to make opening statements.

Mr. BILIRAKIS. Mr. Chairman.

Mr. ROWLAND. The gentleman from Florida.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Mr. Chairman, I commend you for holding this important hearing. I also welcome Secretary Brown and his staff to the subcommittee and look forward to their testimony.

Mr. Chairman, many issues are making national headlines these days, and probably no single issue will impact as many individuals as national health care reform. Obviously, national health care reform has serious implications for the VA health care system—serious implications. Therefore, any proposal that impacts on the status, role, or autonomy of the VA health care system must be closely examined.

Last year, the veterans in my district were concerned, and I would dare say probably veterans all over America, that their health care needs were being overlooked in the debate over a new national health care system. At that time, I urged the VA to become an active player in the debate, and I was encouraged to learn that Secretary Brown was a member of Mrs. Clinton's health care reform task force and that VA staff participated in the various working groups that were formed.

At first glance, it appears that the President's health care proposal will maintain the VA's independence. However, I do have numerous questions regarding whether or not the VA can effectively play the role envisioned for it in the Administration's proposal, and I also have serious doubts as to whether or not the VA will be able to compete with other health care providers.

For years, a tremendous backlog—I believe you mentioned this, Mr. Chairman—in construction projects and medical equipment acquisitions have hampered the VA's ability to treat the Nation's veterans. Unless these and some other concerns are addressed at the start—and I underline the word "start"—of the reform process, I am afraid that the VA will be the last runner to cross the finish line in the race to attract health care consumers. In other words, it would not be competitive.

I have long believed that the VA health care system is a national asset and, I think virtually every member of this committee is committed to ensure that it continues to be one. The men and women who have served in our armed forces have met their obligations to our country, and as we move toward reforming the Nation's health care system we need to show our veterans they have not been forgotten or abandoned.

I had a quote in here from Theodore Roosevelt, but I will pass that up in the interest of time. In closing I want to repeat something that I try to repeat in most of our hearings, and that is to

encourage the members of the veterans' service organizations that are in the audience to remain diligent. The health care debate is far from over. We have got to be open-minded. We have got to reach out and be a part of the solution, but at the same time we have got to be diligent. It is imperative that you continue to be active players in the ongoing deliberations over national health care.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

Thank you Mr. Chairman.

First, let me take this opportunity to commend you for holding this important hearing. I would also like to take a moment to welcome Secretary Brown to the subcommittee. I look forward to hearing his testimony.

Many issues are making national headlines these days, and probably no single issue will impact as many individuals as national health care reform. Obviously, national health care reform has serious implications for the VA health care system. Therefore, any proposal that impacts on the status, role, or autonomy of the VA health care system must be closely examined.

Last year, the veterans in my district were concerned that their health care needs were being overlooked in the debate over a new national health care system. At that time, I urged the VA to become an active player in the debate. Therefore, I was encouraged to learn that Secretary Brown was a member of Mrs. Clinton's health care reform task force and that VA staff participated in the various working groups that were formed.

At first glance, it appears that the President's health care proposal will maintain the VA's independence. However, I do have numerous questions regarding whether or not the VA can effectively play the role envisioned for it in the Administration's proposal. Moreover, I also have serious doubts as to whether or not the VA will be able to compete with other health care providers.

For years, a tremendous backlog in construction projects and medical equipment acquisitions have hampered the VA's ability to treat the Nation's veterans. Unless these and some other concerns are addressed at the *start* of the reform process, I am afraid that the VA will be the last runner to cross the finish line in the race to attract health care consumers.

I have long believed that the VA health care system is a national asset and I am committed to ensuring that it continues to be one. The men and women who have served in our armed forces have met their obligations to our country, and as we move toward reforming the Nation's health care system, we need to show our veterans they have not been forgotten or abandoned.

Theodore Roosevelt once said that "a man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards." I cannot and will not support any reform proposal which abrogates our responsibility to the Nation's veterans.

In closing, I want to encourage the members of the veterans' service organizations that are in the audience to remain diligent. The health care debate is far from over and it is imperative that you continue to be active players in the ongoing deliberations over national health care.

Mr. Chairman, as always, I look forward to working with you and the other members of the committee on this important issue.

Mr. ROWLAND. Thank you.

Do any additional Members desire to make statements at this time? If not, I want to recognize the Honorable Jesse Brown who is Secretary of Veterans Affairs.

Mr. Secretary, thank you very much for being here this morning.

He is accompanied by Dr. John Farrar—thank you Doctor, for being here this morning—and Dr. Vic Raymond—thank you for being here as well—and Mark Catlett, and Ms. Mary Lou Keener.

Mr. Secretary, you may proceed as you so desire.

STATEMENTS OF HON. JESSE BROWN, SECRETARY OF VETERANS AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOHN T. FARRAR, M.D., ACTING UNDER SECRETARY FOR HEALTH; VICTOR P. RAYMOND, Ph.D., ASSISTANT SECRETARY FOR POLICY AND PLANNING; D. MARK CATLETT, ASSISTANT SECRETARY FOR FINANCE AND INFORMATION RESOURCES MANAGEMENT; AND MS. MARY LOU KEENER, GENERAL COUNSEL; AND JUDITH FEDER, Ph.D., PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF HON. JESSE BROWN

Secretary BROWN. Thank you very much, Mr. Chairman. Let me begin by thanking you and the members of the committee for giving me this opportunity to discuss with you the President's plan for national health care reform.

As you know, I was a member of Mrs. Clinton's Health Reform Task Force. VA staff participated fully in all of the work groups that were formed to address issues and develop material for the President's plan. I felt a great sense of hope when the President presented his health care reform proposal to you and other Members of the Congress last month.

I was personally moved when the President said, "This is our chance, this is our journey, and when our work is done, we will all know that we have answered the call of history and met the challenge of our time."

Mr. Chairman, a large part of that challenge involves providing for the health care needs of America's veterans. I am pleased and excited that the President and the First Lady have said that the VA will continue to be an independent health care delivery system, and we believe that the Department of Veterans Affairs health care system will be strengthened by the President's proposal.

The President's plan for national health care reform provides for security for all Americans by ensuring lifetime, affordable health care coverage. All Americans will have the freedom to choose the health care plan that best suits their needs. We believe that the VA is in a position to be a clear choice for many veterans because the VA system is uniquely suited to meet their needs.

I am pleased to say that the major veterans' service organizations were included in the decisionmaking process when the VA's elements of the proposal were considered. So I am confident in telling you that the President's plan is a balanced approach to meet the needs of our veterans. This plan will take us into a new era of dependable, affordable health care. It will increase choices for consumers, control costs, improve the quality of care, reduce paperwork, and provide a comprehensive health care package, and I might add that the word "comprehensive" was not chosen lightly.

All Americans will be guaranteed coverage for the hospital, physician, emergency services, prescription drugs, preventive care, mental health, substance abuse, and much much more. I am very pleased that all veterans who choose to enroll in a VA plan would receive that comprehensive package of health benefits and other specialized services unique to the VA for which they are eligible.

So the reform program is especially good news for veterans. It means that all veterans will have access to the VA. It means that service-connected and low-income veterans who choose the VA will pay nothing for care, no premiums, no co-payments, and no deductibles. It means that service-connected and low-income veterans now eligible for extra VA services not included in the national benefit package will remain eligible for those services, services such as long-term nursing home care, treatment for spinal cord injury, rehabilitation for blind persons, custom-fitted prosthetic devices, dental care, medical services to include eyeglasses, hearing aids, and so forth.

The health care reform proposal means that higher-income veterans can use medicare and other third-party insurance to receive their care from the VA. So this is clearly good news for veterans, and I believe it is also good news for VA.

Since veterans will have a choice of where to get their care, the very existence of the VA will depend on whether veterans choose the VA. Our future will depend on objective comparisons with other providers, and I say it is about time.

For too long the VA has not been treated fairly. The image of the VA's health care services has been badly distorted in the media. Isolated incidents are often reported as indication that the whole system is bad. You and I know better. On the other hand, the good things about the system are seldom reported. It is not news when we do our job and do it well.

So I personally welcome the opportunity to help people to take a fair look at the VA and what we do. Then they will see a history of scientific breakthrough. They will see that our ratings on quality are higher than the national average. They will see our special sensitivity to and our ability to treat conditions that may be related to service. They will see that VA has a solid record of providing quality and specialized care as part of a comprehensive benefit system. And I believe veterans will choose the VA as their health care provider because VA employees are talented, dedicated, and they truly care for our Nation's veterans.

Lincoln's words, "to care for him who shall have borne the battle," are much more than a historical statement. Those words live in the form of compassion and respect which the VA family feels for the veterans whom we serve, and I believe that this will make a real difference to the veterans who will need health care in the future.

Mr. Chairman, we recognize that the VA has to make some changes and improvements in its health care delivery system to make this proposal work. By the same token, this proposal will give us the first opportunity to make the improvements that are needed.

We have a system with large backlogs of equipment and maintenance needs, with an overreliance on inpatient care, with inadequate ambulatory care facilities, and with staffing stretched far, far too thin in some places.

The President's proposal will put the VA's system on a more solid financial footing. This will enable us to make a needed shift toward more primary care and will provide simplified and rational eligibility rules for inpatient and outpatient care.

So you can see why I consider this such a wonderful, wonderful opportunity for the VA. In anticipation of the enactment of national reform, we have many of these implementation steps now in progress, and we are providing and improving our managed care programs and enhancing our ability to deliver primary care. The VA system will be able to continue its support of medical research and health care education and training.

My personal belief is that the VA's participation in national health care reform will allow the VA system to prove that it can be a model because the VA already is a national health care system operating under a global budget; VA already is a managed care program combining cost efficiency with quality assurance; VA already has demonstrated how to pay the bills through combinations of appropriated funds and third-party reimbursements; and VA already offers comprehensive care ranging from preventive services through specialized care for the aging.

Mr. Chairman, I cannot state strongly enough our willingness to work with you to address the points in the plan that may not be clear and to, of course, answer questions. I believe that the President's proposal preserves the VA health care system for the Nation's veterans and for the first time in history provides the means to allow our veterans to gain access to their system.

Mr. Chairman, this concludes my testimony, and of course I will be delighted to respond to any questions that you and the members of this committee may have.

[The prepared statement of Secretary Brown appears at p. 89.]

Mr. ROWLAND. Thank you, Mr. Secretary.

Joining us at the witness table now is Dr. Judith Feder. She was chair of the working groups of the President's health care task force and our principal deputy secretary for planning and evaluation of the Department of Health and Human Services.

Welcome, and we thank you very much for being here today. We would be pleased to hear an opening statement if you have one.

STATEMENT OF JUDITH FEDER, Ph.D.

Ms. FEDER. Thank you, Mr. Chairman. It is a pleasure to be here today.

I don't have an opening statement except to say that throughout our work on health reform it has been the view that all Americans and all components must be part of that system and that the veterans system has a vital role to play in that system and in health reform, and I can only say that I share the Secretary's enthusiasm for the changes we propose and look forward to working with you in making this the best proposal we can.

Mr. ROWLAND. Thank you very much.

Mr. Secretary, as I understand it, the President's plan calls for a national health board whose role would include setting national standards. The President has certainly been sensitive to the concerns of veterans that the health system in the VA remain independent. What assurance do you have that the board will not deprive you of the independence that you now have under law?

Secretary BROWN. Well, I think that we have to look at this in the entire context of what the President envisioned in terms of

bringing quality health care to all Americans, to include our veterans.

Under his proposal, the VA will actually compete primarily at the same level as other providers in the overall health care reform initiative, and I think in that alone we will be based and judged on how well we perform, and we believe, based upon our experience, the resources that we already have, to include the new features that will be added to the program, that we will be very, very well treated, and we do not have any concerns about being put at a disadvantage as a result of this proposal.

Mr. ROWLAND. You don't think that the national health board may at some time in the future have a tendency to want to usurp the authority or take away some of the authority that you now have under law as an independent health delivery system?

Secretary BROWN. Well, at least based upon the draft information that we have, the President has made it clear that the VA will remain an independent system. He has also made it clear that basically Federal regulation, Federal policy, will prevail.

Now of course there will be some instances where we will have to adjust; for instance, if we happen to have a VA facility in a State that wants to go to a single-payer source. In that instance, we will have to make the adjustment in order to be able to be competitive in that environment. But I do not see that as a disadvantage, quite frankly, I see it serving the best interests of veterans and, of course, in the much larger context, to bring some sanity to the problems we are having in our health care deliver system today.

Mr. ROWLAND. We have a vote now, and there is probably about 7 minutes left to get over there. We will leave and immediately come back. I will return immediately to continue questioning, and I hope that other Members will return as well. So we will stand in recess until we can go over and immediately come back.

[Recess.]

Mr. ROWLAND. We will continue now with questioning.

Dr. Feder, did you wish to respond to the question that I directed to the Secretary?

Ms. FEDER. Yes, sir, Mr. Chairman. I wanted to clarify that the national board has very clearly defined responsibilities. They have to do with updating the guaranteed benefit package, assuring the compliance with premium targets, quality assurance, and State compliance with overall requirements and national guarantees under the plan, and none of those, as you can hear, have any bearing on the nature of the veterans' programs.

Mr. ROWLAND. Let me ask you this. Given the VA's stature and unique experience as a national health care system, which operated for many years on a global budget, it has been proposed that the President's Health Security Act provide a statutory role on the national health board for the Secretary of Veterans Affairs. Does the Administration support that proposal?

Ms. FEDER. Let me describe to you the purpose of the national board. I indicated its functions. It is structured as an independent board in part to insulate it as it deals with the decisions I have described from a number of the pressures that face executive departments and face the Members of Congress, and so the desire is to have it as an independent agency.

Its membership is also premised on the basis of an absence of any kind of conflicts of interest, any interests in managing the health care system, and, as the Secretary was indicating, the Department of Veterans Affairs is essentially in some respects a provider under this system, and consistent with that role, or based on that role, it may be that that is not an appropriate place for it.

Mr. ROWLAND. Am I to understand then that there will not be any member of the board that would be involved in providing——

Ms. FEDER. That is correct. At that time, essentially, that the role—because the role would be regarded as a conflict.

Mr. ROWLAND. But the board could have someone on it who had been a provider at some time in the past.

Ms. FEDER. That is correct.

Mr. ROWLAND. That is correct.

Ms. FEDER. That is correct, with protections against leaving the board and so on.

Mr. ROWLAND. Then you would not object to some individual who had been involved at some time in the VA health care delivery system, who was not at that particular time actively involved, being a member of the board then?

Ms. FEDER. I don't see anything that would prohibit that selection.

Mr. ROWLAND. Dr. Raymond, the Department's testimony states that the VA plan would provide veterans a guarantee of care. How substantial is that guarantee? Isn't it largely dependent on your success in the as yet untested and highly complex job of forecasting who will enroll for VA care, what the revenue sources will be, and where it will come from, and how large an appropriation would be required?

Mr. RAYMOND. I might ask Dr. Feder to follow my answer, but in fact the design of the national plan in which the VA would participate or could participate as a provider requires each provider to deliver the comprehensive benefit package. No matter how many people—how many veterans—signed up for the VA as a provider source, we would be required and would be provided monies to deliver the full of range of services.

Now the total amount of money that would be required and the magnitude of some changes that might be required to set up under the health alliances would be related to the total number of veterans who apply. But the comprehensive benefit package is, in fact, to fulfill the President's desire that every citizen have a reliable source of needed care of a defined scope.

Mr. ROWLAND. I think my time has expired. I will come back to that point.

Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. Secretary, recently I introduced a long-term health care bill along with some of my colleagues, H.R. 3122, based on a strong belief that the VA must have a clearly identified long-term health care mission for those approximately nine million veterans that are going to be over the age of 65 by the year 2000.

Under the President's plan, how would the VA expect to meet the long-term care needs of this population?

Secretary BROWN. Under the President's plan, the basic, comprehensive, standard package would provide long-term care probably up to 100 days. That is generally the maximum there. If you need additional, you then have to start looking toward medicaid in order to provide additional time.

One of the things that the President has made clear is that no veteran would lose any entitlement that he or she already has. Therefore, what we would look to do and to make sure that it is preserved is that every veteran that is presently entitled or who may be entitled under the present criteria to long-term care, we would continue to provide that as a supplemental package over and above the basic comprehensive package.

Mr. STUMP. Well, of course, there is no entitlement to long-term care now. That was the reason I introduced this bill, to encourage the VA to accommodate a rapidly aging veteran population. I would appreciate very much if you would look at the bill and respond as to whether provisions of this bill could be incorporated into the President's plan if it is passed, or, if the President's plan is not passed, could provisions be incorporated into a separate eligibility reform effort, assuming the bill passes through this committee in the next few months?

Secretary BROWN. Yes. Obviously, we did not come prepared—I am familiar with your legislation, but we did not come prepared to discuss it. I will be happy to take a look at it and provide you an analysis of it and share with you our opinion.

Mr. STUMP. I would appreciate that.

Mr. Chairman, I have some other questions, but I will wait until it comes back around, because I know we are going to have another vote. If not, I will submit them for the record.

Secretary BROWN. There is one other point I would like to follow up on that. While the President's basic plan at this point only calls for about 100 days, I think we do have to look in the outyears. By the year, I think, about 2000 we expect—at least the Administration expects to add long-term care, nursing home care, as part of the standard package.

Ms. FEDER. I am glad to have that opportunity to clarify. I think that not with the focus on nursing home care but from an earlier period, a long-term care focusing on home and community-based services which are so lacking in the current system are a part of the reform. They are not part of the guaranteed package that is largely employer financed, they are provided through a separate program that is largely Federally funded, available to all persons with severe disabilities, and we would expect that to greatly expand the availability of these services to all people who are disabled or have disabilities throughout the country. So that is a critical component of the reform package.

Mr. STUMP. But this would not occur, you say, until perhaps the year 2000?

Ms. FEDER. No. The Secretary was referring to, actually, is that it is phased in over time. It begins most likely in 1996 or 1997 and then is phased in over a period. So it begins essentially simultaneous with the guarantee of universal coverage through the guaranteed package but is phased in over a somewhat longer period.

Mr. STUMP. Thank you, Doctor.

Mr. ROWLAND. Thank you, Mr. Stump.
Mr. Applegate.

OPENING STATEMENT OF HON. DOUPLAS P. APPLEGATE

Mr. APPLEGATE. Thank you, Mr. Chairman.

Mr. Secretary, thanks for being here before the committee and laying out your views on the veterans' participation.

I would just like say to the committee and to others that I have known the Secretary for a good many years, as many of you have, and have always found him to be extremely competent but also an individual who communicates well in all the positions that you have held. I won't try to enumerate how many you have had over the years of service with the Disabled American Veterans, and then of course of to carry that over to the VA I think is remarkable in itself. You don't end up as an opponent, but you do end up on sort of the other side, looking at it from a different perspective, and I think that you have handled that well. So my hat is off to you for that. And I agree with you, and I think with most.

I think that the President's program is basically very sound and it is very good. There are going to be a lot of questions. We are going to be working on this for the next 10 to 12 months before we are going to be able to put the whole thing together, and I know that there will be some changes.

I guess when the question was asked as to how much it was going to cost to make the system competitive, that there were no figures available, and I can understand that at this particular point.

But I would say this to you, that whatever you do in order to try to make it competitive—and I know that you believe that the health care system as good, I think, as you have been quoted, as any hospital in the country. However, I would say this, that if I was to ask my veterans in my area if they wanted to go to the Cleveland VA hospital or the Cleveland Clinic, you would probably get about 98 percent that would want to go to the Cleveland clinic.

I have heard a lot of horror stories from a lot of people who come into my office who, from the moment that they step inside of a veterans' hospital, are treated like a dog. The moment that they go talk to the receptionist, they treat them like a nonperson, and it is somewhat of an embarrassing situation. Then they come to me because I am part of the Government that has developed this system.

I know that there are some who would argue that it is a great system, and it may well be, but it is a huge system, and I think that there is a great deal that needs to be done to really give it the quality that the veterans deserve; and I think under your leadership and under the President's leadership, this can be accomplished.

Let me ask you a question here, and I think I know what the answer might be, but I am not sure. Concerning self-employed service-connected veterans, would they be expected to make any payments for their care if they choose the VA as their provider?

Secretary BROWN. Mr. Applegate, obviously that is an excellent question. It is a question that was of concern to myself and the service organizations, because essentially what you end up having

is a situation where a self-employed veteran ends up paying for his own care.

We spoke with the White House over this just in the last 24 hours, and I am happy to report here for the first time that the President agrees that we need to set in motion a mechanism by which our service-connected self-employed veterans will pay nothing for their care.

What we are proposing, which we are in the process of developing guidelines, would be a procedure by which the self-employed veteran, like everyone else, would pay into the alliance. Once he enrolls into the VA's defined health care and we receive his money, we would then reimburse those funds directly to him. So, in effect, he ends up paying absolutely nothing for his care. So I am happy to announce that for the first time.

Mr. APPLEGATE. That is good.

Let me ask you this, Mr. Secretary. Will all 27 million veterans be eligible for care? In other words, is this going to be not just for low-income and service-connected but for all veterans who served at any time during any period of time while they were in the service?

Secretary BROWN. Yes, sir.

Mr. APPLEGATE. But not their families, right?

Secretary BROWN. What we propose to do is to provide care, at least access, to all 27 million veterans. Those 27 million—the 2.5 million that we are currently treating, our service-connected, and our low-income veterans, they will continue to receive their care, and it is paid for primarily through appropriated funding. The other 25 million, let's say, that have been basically locked out of the system for the last 20 years or so, that group will gain access to the system through their employee contribution, and also those that are entitled to medicare would pay, and we would retain those funds.

Now with respect to the families, while we are not at this point ready to treat directly the dependents of veterans, but for those that are enrolled in our plan, we would manage the care of their dependents. So in other words, if a veteran enrolls in a VA plan and he is sick, we take care of all his needs. If his wife is sick, we contract that out with another provider in the alliance. So that way we manage the entire care of the family unit, and I think that that is going to work well as we move more toward a competitive environment.

Mr. APPLEGATE. I thank you. My time is up, and I appreciate your willingness to answer those questions. Thank you, Mr. Secretary.

Secretary BROWN. Thank you, sir.

Mr. ROWLAND. Thank you, Mr. Applegate.

Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman.

Mr. Secretary, will service-connected disabled veterans continue to be treated within the VA on a prioritized basis?

Secretary BROWN. Well, under this plan, number one, in order to qualify for the plan, each provider will have to be able to provide the comprehensive benefits that are outlined in the President's plan, and, as such, we will provide the care in the same manner

as any other institution will provide it, and I think someone else mentioned—Mr. Applegate was talking about our ability to be competitive. One of the things we have to do is to make sure that if a veteran comes into the Cleveland Clinic or a patient comes into the Cleveland Clinic and he or she needs care, they get that care in a timely manner, whether they are service-connected or not service-connected. In this case, it would be just a private civilian.

What we want to do is to have that same kind of operation in the VA. Whoever comes into the VA will be able to get quality care immediately in a timely fashion. So hopefully there will not be a need to establish priorities. If we are going to be competitive, I don't see how we can ask people that are paying into the system to wait. So I think that our overall goal would be to provide immediate care on demand.

Mr. SMITH. So if I understand correctly, the priority that service-connected disabled veterans have received traditionally within the VA will no longer be in existence?

Secretary BROWN. Well, I do not want to go on record as saying that. I only want to go on record as saying that our goal at this time as we move toward the implementation process, our goal is to make sure that any veteran who is enrolled in our system gets timely, immediate consideration for whatever medical problems that need to be resolved. That is our goal.

Mr. SMITH. But I am concerned about what the reality will be, particularly in the first few years. We know that our VA health care network is overburdened rather than underburdened, and we have a number of facilities that can't meet the existing demand already, and that is with service-connected disabled veterans getting priority care.

Unless there is a massive building program in the plans over at the VA, I am not sure how you accommodate this massive influx of veterans as they come in, unless we are looking at contracting out, which may be on the horizon as well.

Secretary BROWN. Well, let me respond to that because I think it is a legitimate concern.

First of all, we will have a mandate, I think probably a legal obligation, to be able to provide this standardized package in a timely fashion. I think we have to do that. I think that we are going to be able to meet that challenge because under the President's plan we will be able to expand our system based upon new funding streams that will be made available to us.

Obviously, what we need to do is to look at exactly what we can provide. The problem that we have now is, we have a lot of unutilized or so-called excess capacity in our system simply because we have not had historically the resources in order to provide that care.

Under the President's plan, I think that we will have those resources, and then we are going to start managing this whole system like a business. We are going to expand our outpatient clinics, we are going to expand our ambulatory services and so forth, and I think that by taking that approach we will be able to take care of all veterans who want treatment and enroll in our system.

Mr. SMITH. Just for the record, let me note my concern that service-connected disabled veterans might not get the kind of priority

that they deserve, particularly due to competition and a shaping and framing of services aimed at attracting additional clients in this competitive environment.

Mr. Secretary, the President's plan indicates a $9 billion savings from VA health care over 5 years. My question is, how can the VA, which is currently underfunded, sustain reductions of approximately $2 billion per year over the next 5 years and meet all of this new demand you claim the Administration's proposal will create? And if you could provide to the committee a very complete analysis on how these figures, $9 billion, were arrived at.

Secretary BROWN. Okay. I am going to ask Mark Catlett to respond to that. We can provide you with an answer.

Mr. CATLETT. Mr. Smith, that was an earlier estimate made at the time by the Administration of a shifting from budget authority to these other sources that the Secretary has spoken about, other revenue streams that we will have. Those estimates are now being reviewed again, so I would ask that once we have those, and certainly we will be ready to provide to the committee, we will do that.

But that is an estimate not of a reduction of the VA's funding, it is just a shifting of that funding from appropriations to the other funding sources, the alliance contributions and medicare.

Mr. SMITH. Let me ask a question with regard to the proposed Veterans' Service Areas. I believe there are 16 VSAs currently on the board in draft form. The regional alliances to be constructed within the President's plan envisions the States taking the main leadership on this. How do the alliances interface the veterans' parameters, the boundaries that are established, which, obviously, cut across State lines? How does that all work out?

Secretary BROWN. You are absolutely right. Under the President's plan, we will probably, in most instances, be governed by the overall direction that is provided by the States.

I am going to ask Dr. Farrar to give additional information on exactly how we plan on dealing with the question of boundaries as you mentioned.

Dr. FARRAR. Mr. Smith, in order to be competitive, we feel that we need to reorganize the VHA into groups which are very close to where the patient is, and currently we are working on a Veterans' Service Area proposal, which is very similar to what the Commission on the Future Structure of Veterans Health Care had suggested.

I think that we have not yet sent that over. It has not yet been approved by Secretary Brown, but we are thinking very much of having a group of maybe 16, maybe 18 Veterans' Service Areas to empower the field and delegate more authority and responsibility to the individual medical centers.

Now, Mary Lou Keener has been on a task force for the last few days. She has been dealing with how we are going to respond to the various State initiatives. If we could ask Mary Lou.

Ms. KEENER. Mr. Smith, we anticipate that there will probably be several States that will gear up and begin to implement plans prior to the time that any Federal plan is actually initiated. In anticipation of that, we are looking at what legislative action might be necessary to allow us to participate in these plans as they begin to evolve. We don't want to wait around for the Federal initiative

and not be able to operate in States that may gear up with plans prior to that time.

If we are to truly participate in the state plans, there is a lot of immediate legislative relief that will be necessary. For example, if we intend to be on a level playing field, and if we are to compete with other plans on this same playing field, we will have to have immediate relief, for example, from restrictions concerning our ability to advertise, or market our product.

We certainly will have to have your help to allow us to proceed in some of these areas that will now restrict our meaningful participation.

Mr. SMITH. I will have some questions for the second round, but in follow up to that, briefly, is it conceivable then that some States will move ahead as you said of the Federal plan and we have the potential of service-connected disabled veterans in some of our VA hospitals and outpatient clinics not getting priority treatment in some States and getting priority treatment in others?

I mean that concerns me as well, that there could be unequal treatment of those veterans. I remain concerned that they are first, second and third in terms of our concerns, and all of the veterans, obviously, are concerned as well that they are first.

Secretary BROWN. The questions that you raise, obviously, are good questions. One of the reasons why we want to set up these pilot projects is because we have identified approximately 13 States that may be able to come on line right away. Washington State may be able to come on line as early as January 1995.

So what we want to be able to do is to create kind of like a microcosm of what to expect, and from that not only will we able to get a vision on how we will be able to react in the future, but we will gain a lot of knowledge how we should behave once we start implementing this situation countrywide.

I might say this to you, though, that the system would not work if service-connected veterans or any veteran is not able to get timely comprehensive care. It simply cannot work because we are asking people to make a choice between some of the finest institutions in this entire country.

You take Baltimore that has Johns Hopkins University. We have a wonderful institution right down the street from that, and if a veteran, who will have choice—and that is one of the beautiful aspects of this program, he will have a choice to go to Johns Hopkins or go to the VA—if we are going to encourage him to come to the VA, we are going to have to be competitive and competitiveness has to do with access, competent, quality care in a timely fashion, and I think we are going to be able to meet that objective.

Ms. FEDER. Mr. Smith, it may help to clarify that essentially we are talking about phasing in the overall health reform as States are ready to come on line. So we are not talking about States coming in advance of the health reform, we are talking about the States who come in early in the overall health reform. Okay?

Mr. ROWLAND. I thank the witnesses.

The Chair will attempt to recognize Members in the order in which they came in, alternating one side with the other, and I would ask Members as nearly as possible to adhere to a 5-minute time limit.

Dr. Kreidler would be next.

OPENING STATEMENT OF HON. MIKE KREIDLER

Mr. KREIDLER. Thank you very much, Mr. Chairman.

Ms. Keener, you had already answered in part the question I was going to ask, because the State that is by far the furthest along right now with health care reform would be my home State of Washington, which has already enacted legislation that is almost identical to the health reform that the Clinton administration is going to be submitting to the Congress.

Therefore, I would assume, since it so closely parallels, it will be recognized early in this process by the national plan, but on top of that, it would act independently, presuming that the Federal Government gives them some relief from certain things like ERISA and medicare and medicaid.

It appears from what you are saying now in the States like Washington, the VA system would seek assistance immediately so that it effectively would not be shut out of the State plans as they were evolving; is that correct?

Ms. KEENER. Yes, sir. That is correct.

Secretary BROWN. I think, Mr. Kreidler, that is so important. Let me just give you some examples on why that is important, to create a level playing field here.

Just the question of advertising. We are prohibited from advertising. If we are going to be competitive in the alliance in Washington State, regardless of whatever form that it takes, we have to advertise right along with the other hospital medical providers in that State.

Another area that we are very concerned about under our care groups, particularly with respect to outpatient care, we know that is the most efficient form of care; that is the form of care that will explode in the future because of the new advances being made in treatment modalities, but because we cannot treat a veteran who needs management of a, let's say nonservice-connected diabetic condition or hypertension on an outpatient basis, we have to put him in the hospital to take care of him, and then put him on an outpatient.

So we need to change the rules immediately so that we can create kind of like a microcosm of what we expect in the future. You are absolutely correct Washington State is one of those States that we have identified that we are going to take a very close look at.

Mr. KREIDLER. Good. It would appear to me if you did not seek that that you could see a substantial number of the people who access care through the VA system who will have then enrolled in plans and not be potentially attracted back to a VA-HMO plan that might exist at some time in the future and it would be very difficult then for the VA medical system, in the State of Washington, for example, to maybe be competitive, be able to offer their services, to keep the VA medical plan alive and well.

Secretary BROWN. You are reading our minds.

Mr. KREIDLER. In the State of Washington we have a very strong cooperative working relationship between the VA hospitals and military hospitals, particularly Madigan, and you, Mr. Secretary, heard testimony to that when you visited out there.

Do you anticipate that that same kind of working relationship would continue under the reform, where the VA medical system and the military medical system would continue to work cooperatively?

Secretary BROWN. Yes. I think what we are going to see here, we are going to see many forms of sharing agreements take place here, particularly between providers that are closely geographically situated.

For instance, it does not make sense to have say a CAT scan that is owned by the VA and one that is owned by a military installation within 4 or 5 miles of each other. We need to be able—the whole idea is to create additional efficiencies and use the economies of scale to our best interests.

So what we need to look at is whenever that situation presents itself, then we need to seize upon it. So, yes, we will be looking at that.

The other thing we will be looking at is the military itself, it is organizing its whole operation as a health care provider, much like we are. They are taking a different approach, but because they are, we will be able to share various kinds of services between the providers in the alliance.

Contracting out is going to be very, very important to us. As a member of the alliance, we, as I mentioned to you, will have an obligation to provide all of the services that are mandated by the national board. If we cannot do them in the VA for whatever reason, then we will contract them out. So that way we are taking advantage of all the existing resources in any given area and I think it will be cost effective and improve the quality of care.

Mr. KREIDLER. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROWLAND. There is a vote on the Floor now on an amendment, and as I understand, we may vote on the amendment; there is a possible vote on recommittal and a vote on final passage, which will necessitate us being gone probably 20 to 30 minutes. It is one of the hazards that we have, so I ask for your indulgence while we do that and we will stand in recess.

[Brief recess.]

Mr. ROWLAND. We finished voting a little more quickly than I thought that we would, since we didn't have to vote on recommittal, so we will be able to get started back sooner than I had expected. Since there are no other Members here at this point, I will go ahead and start some questioning that I had and we will recognize them as they come in.

I want to go back to the question that I had asked Dr. Raymond earlier about the uncertainty of funds; where they would be coming from.

The VA medical care appropriations funding level has been erratic over the years, as you know. This plan still relies heavily on that appropriation to fund care. Given the past history and given a plan which also envisions partial funding of VA care coming from employer premiums and third-party reimbursements and medicare, what mechanism will be proposed to ensure appropriations will be adequate to deliver the care that the VA health plan promises?

I will be glad for Dr. Raymond or Mr. Catlett or anyone to deal with that.

Secretary BROWN. Well, let me start off and then I would like to ask Dr. Raymond to make additional observations and also Mr. Catlett.

I think one of the beautiful things about the Clinton plan is that for the first time it provides funding streams to the VA that is stable, that makes some kind of sense. If you look at the VA's budget over the last 25 years, at a time when we had thousands of people being wounded in Vietnam, at a time when we had our World War II veterans getting older and needing more and more expensive geriatric care and long-term care and so forth, our budget was at a flat line. And, of course, this put us in kind of an awkward situation.

We are not operating at full capacity all around the country not because there is a lack of demand, it is simply we do not have—there is a lack of resources in order to put those beds into operation. That is one of the things that we have been very, very concerned about.

Another point that follows up on that, because there was a lack of resources, we had to restrict the admission criteria to veterans that were previously eligible to come into our health care delivery system, and that is where we ended up with the so-called Category A, B, C, and so forth. So now we are only treating category A's simply because we do not have the money.

Under the President's plan we have new sources of revenue that I think will allow us to be competitive by providing resources so that we can renovate our infrastructure in some of our hospitals.

I was talking to one Member of Congress today. In one of our hospitals on the East Coast we still have wards there. There are four to six patients in a ward. Well, obviously we cannot be competitive under that situation, especially this Member happened to be in a district that has some of the country's greatest medical schools. So we need to be able to look at that if we are going to survive. I think the Clinton plan takes that into consideration.

For instance, under the Clinton plan, there are a number of funding mechanisms that will be available to us. Number one, we would hope to continue the appropriation process for primarily the care of our service-connected and our low-income, nonservice-connected veterans.

Number two, we would, for every veteran that is enrolled into our system, we would get a funding stream directly from the alliance to care for that veteran's care, in some cases for the dependents of that veteran, although we would contract out the care for the dependents.

Number three, we have another important source for the first time of new revenues primarily coming from medicare and other third-party insurers which we would be able to retain at the local level, all of which bring in a new stable source of funding.

Now, obviously, there are some pitfalls in that, and the pitfalls have to do with when you look at these new funding sources you say, well, you have new money coming in from this source so we are going to reduce your appropriations. Well, we will have to look

to our friends in this committee and the entire Congress to make sure that does not happen.

I do not believe that there is any member in the entire Congress that would want the VA to fail. In order for us not to fail, we are going to have to have these new revenues in order to allow us to bring our system up to a level that we can provide timely and quality care in an efficient manner.

With that, I would like Victor to make some additional remarks.

Mr. RAYMOND. I am not sure I have a great deal to add to what the Secretary said. I think that was a complete answer. Let me give an example of some discussions you and I have had over the years about what would make it easier for the VA and more predictable for the VA to build a budget and for this committee and others to consider that budget.

We needed some better predictability in how many veterans were coming in. Under this health plan, because of the enrollment part, we will be able to know in advance how many veterans will be getting care.

The other part that would have helped us was to have a clear definition of what the service package was. The way that HMOs and other private sector operations predict cost and whatnot is knowing in advance who is coming and what they are going to provide. This, with the guaranteed benefit package, will be provided now to the VA.

The third piece, then, is to have some way to measure how much money would be necessary for an individual to receive the benefit package. With the health alliance construct, we ought to be able in terms of our appropriations budget to better project the kinds of costs that would be attendant to a person and the guaranteed benefit package.

The piece that will be still somewhat unpredictable would be those services beyond the standard benefit package which certain veterans would still have access to in sort of a supplemental way. I think that this plan, as a conceptual matter and a practical matter in building a budget, will help us because it increases our predictability.

Mr. ROWLAND. The gentleman from Florida.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I am trying to catch my breath, to be honest with you, that was why I was not in any great hurry.

Mr. Secretary, you have served as Executive Director of the DAV, been involved in this business in one capacity or another, as was mentioned earlier, for years and years, and certainly recognized that veterans have been very concerned about guarding an independent, separate veterans health care system over the years. In that connection, I ask the question, will the VA continue, as it was established decades ago, to have a separate budget?

One of you mentioned the appropriation process. We always fought for those dollars, without ever getting adequate dollars. You have certainly been one of the proponents of that point of view over the years.

Will the VA continue to have a separate budget, such as it is, or will it be part of the global budget for health care?

Secretary BROWN. I would think that is something that we are going to have to work out. But my personal view is that we would have a separate budget, dealing with the appropriation that will be made available to care for our service-connected and our low income, plus there are other things that are included in the supplemental part of our package that must be paid for through the supplemental package, such as our vet centers, such as the long-term nursing home care, our SCI units. Programs like that will have to be paid for through the appropriations.

Mr. BILIRAKIS. With all due respect, I realize you are really on the spot here because there is no health plan that has come in from the White House yet, and we don't know what the details are. I am also on the Health and Environment Subcommittee of Energy and Commerce and we have had hearing after hearing on this issue and we still don't know the details.

You are shaking your head, Doctor Feder, but with all due respect, we still do not have any of the details. You preface your remarks with the word, "I think," and I think you really mean that you are going to fight for these things. But I have here a VA document entitled "Keeping the Promise: VA and National Health Care Reform Overview," it says that "VA reorganizes and manages VA health care plans within health alliances to provide a comprehensive national benefits package to all veterans who enroll in the VA plan."

We further go on to the page on the Health Security Act, VA and National Health Care Reform Financing. "It says financing for the cost of standard benefits would come primarily from premium payments from the health alliances, from HA's, primarily from the premium payments and employers, and employers for veterans selecting the VA plan."

So, we are not talking about a separate health care program at all, are we?

Secretary BROWN. Yes, we are. I see nothing that you said that is contrary to the position that I have taken here. Nothing whatsoever.

Obviously, I think that everyone understood that when we were invited to testify here today that we were talking about the broad outline, the conceptualization of this program. We do not have the details as of yet, but you can rest assured we are working hard on those details and once those details are ready and incorporated into a legislative package they will get right over here and we are hoping that you will support them.

So nothing that was said was contrary to what we are talking about. As I mentioned to you, there are a number of funding streams here: The appropriation process to take care of our service-connected, low-income veterans, and also all of the other supplemental packages that will be made available. We are talking about, for every veteran that is enrolled in our system, we are talking about reimbursement from the alliance for that enrollee and, in some instances, his family. And, of course, new income coming in from third-party insurers.

Mr. BILIRAKIS. So again, VA health care will be dependent upon all of these sources to get funding, including employers, including,

as was mentioned earlier, the self-employed. I appreciate your comments in that regard.

Let me just continue for a moment. Awfully fast 5 minutes.

You will remember the problems we had with the Rural Health Care Initiative, sir. The plan states, as I understand it, that VA facilities serve as providers to other plans and to Medicare on a reimbursable basis. So I ask, is this another rural health care initiative?

Does this mean a draft dodger may actually get care at a VA facility if he falls in one of these other categories? What has happened to the mainstream concern that all veterans have had and all the service organizations have had over the years?

Secretary BROWN. Well, the President has made it clear, absolutely clear, that this is a system for veterans. He insisted on that from the very, very beginning, from the outset of our efforts to bring some rational basis to our health care delivery system, including the VA, and we are not backing away from that.

Now, the section I think that you are referring to has basically to do with this. Under our overall concept of providing comprehensive health care, we will have the authority to enter into contractual agreements with other health care providers. Let's say I have a veteran who needs a heart transplant. I do not have the facilities in this particular defined plan in a given State. So I will contract, let's say with this other plan to take care of that.

Now, that other plan will have the option of doing the same thing, but if that person he wants to refer back to us happens to be a nonveteran, we will not accept him.

So we are not talking about allowing nonveterans in the VA hospital at all. That has never even entered the picture. Now, what we are saying is that there are some instances where we have to be, we have to look at what may evolve after we gain some experience.

Let's say that we open this system up to all 27 million veterans, then all of a sudden we find in the outyears we still have some excess capacity. Then, obviously, the question is what are you going to do about it? I think we don't have to look to nonveterans to find the solution.

We can look to the dependents of veterans that are enrolled in our system. We can actually look, in some instances, if we wanted to, of providing care to those on active military duty. We can look to providing care to CHAMPUS on a much wider basis.

So there are a lot of things we can do to fill that excess capacity without looking outside of the system.

I know Dr. Feder wanted to make an additional comment, so you go ahead.

Ms. FEDER. You commented I was shaking my head, and it was because although we do not have yet a legislative proposal here, we have very clear language and description of the budget, which I believe addresses your question. The budget is best understood as a constraint on premiums in the alliances. It does not have an effect on the VA appropriation. It is a constraint on the premiums.

So I thought that that clarification would alleviate some of your concern.

Mr. BILIRAKIS. I look at language, such as VA reorganizes and manages VA health plans, and it scares me, quite frankly.

Mr. Secretary, you have the influence and you have the power to be protective on behalf of all veterans, as far as these areas that you and I and veterans all over the country have been concerned with over the years. I trust that you will use that influence and that power. I am, frankly, very, very much concerned unless we, all veterans, are going to basically say, well, look, it is worth it to give up our independence, it is worth it to give up the separate veterans health care, the concern about mainstreaming and just be part of the overall picture—if that is going to be the attitude, then so be it. But if we really want to stick to it, we are going to have to be, again I use that word, diligent.

And certainly not meaning any reflection on you when I say that. I hope you understand that.

Secretary BROWN. Yes, sir and I really appreciate your observations and I take them in the spirit in which you offer them. I don't think that is the case. That is not the intent of the President. That is not the intent of the veterans' service organizations and that is certainly not my intent.

I think what is going to happen here is that if we keep our eye on the prize, that is to provide total comprehensive quality health care and access to our 27 million veterans, and we cooperate together with the Administration, the service organizations and of course this august body, that we will be the leader in the delivery of health care as we move into the 21st Century.

Mr. BILIRAKIS. Thank you for that.

Thank you, Mr. Secretary. Thank you, Doctor.

Mr. ROWLAND. Dr. Feder, I understand that you have a four o'clock engagement.

Ms. FEDER. That is correct, Mr. Chairman. I am sorry I am not able to stay and hope I will have another opportunity.

Mr. ROWLAND. We will look forward to your coming back again and we appreciate your being here.

Ms. FEDER. Thank you very much.

Mr. ROWLAND. Mr. Tejeda.

OPENING STATEMENT OF HON. FRANK TEJEDA

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. Secretary, in my district, several counties have no hospitals and no doctors, no clinics whatsoever. How does the VA intend to provide the expanded care outlined in the plan to veterans who choose the VA as their health care plan or their health care provider in rural areas or underserved areas?

There are several counties in my district in south Texas have no primary care providers. The VA Audie Murphy Hospital is about 250 to 300 miles from some of them. I know there are some clinics in McAllen, Corpus and Laredo, but that is still a way off.

Many in the veterans population are World War II Veterans that are well into their 70s and cannot drive 50, 60, 70 miles, as they have to in some cases. What plans does the VA have in those areas for those veterans who do choose the VA and there are no primary care providers, no hospitals?

Secretary BROWN. Yes, sir. I think the question that you raise is a question that is not only of concern to veterans living in rural areas, but is also a concern of the President to provide good comprehensive health care to all Americans living in rural areas, and we are taking that challenge very seriously. That is one of the reasons why we are looking very carefully at how we are going to provide that care.

At this point we are looking primarily at an expansion of our outpatient clinics and ambulatory care centers. We are looking at entering into stronger and much more comprehensive sharing arrangements and contracts with other providers in the alliance.

We are working very hard on that, sir, and I can tell you that as soon as that information is available, we will get that over here as part of our legislative initiative.

Dr. Farrar wanted to make another point.

Dr. FARRAR. If I can amplify a bit on the Secretary's comments. We do plan on finding a way to open clinics, but I think there is another point. We are stressing very much the concept of primary care and managed care so that we will have in these clinics not just physicians but nurse practitioners and a group of people in the community having relationship with our tertiary hospitals where we can give primary care, and then if the patient needs to go to a hospital we will have them in the hospital.

As the Secretary said earlier, we must get our waiting time down sufficiently so if somebody needs to see a specialist it will be that week, if not the following day.

Mr. TEJEDA. You know, I appreciate learning that, about the expansion, and I have been in touch with Jose Coronado from the Audie Murphy VA Medical Center, and I believe perhaps he is recommending that also. But this expansion, if it does come about, will that result in the hiring of new personnel or the shifting of currently scarce personnel from overburdened VA hospitals? How does the VA intend to pay for this expansion?

Secretary BROWN. Obviously, in my view, we do not have the details yet, but we are talking about it as you so adequately put it, an expansion of the system. When you are talking about expanding the system and at the same time making the system much more responsive and sensitive in terms of timeliness and in terms of managing the quality of care, that is going to require additional resources.

I did mention to you that, under the President's plan, we have a number of streams of resources that are coming into the system and we believe that that money is going to help us accomplish the goals that you, that prompted the question that you asked, sir.

Mr. TEJEDA. Thank you. Just one more time, and I appreciate those answers, but just one more time, and I believe you may have touched on it and covered it in your initial remarks. Will a service-connected veteran and/or his employer be required to pay a health care premium?

Secretary BROWN. Yes. Under the plan that is being proposed in its present form, a self-employed service-connected veteran would pay absolutely nothing for his care. He will pay and he will not pay and by that I mean this. This is what will happen.

A self-employed veteran is considered under the national plan as a small business, and as a small business he has to pay for his care. He pays his 80 percent into the alliance. Now, if he or she selects the VA as a health care provider, the President just today has authorized that the VA refund that money back to that individual.

Now, with respect to the other service-connected veterans, under the President's plan when we talk about service-connected veterans, we are talking those that are rated from zero all the way up. Those individuals, if they are employed, their employer would pay into the alliance and they themselves would pay no copayments. So the net effect is our service-connected veterans would absolutely pay nothing for their care; nothing whatsoever.

Mr. TEJEDA. And this final comment won't take but just a few seconds. I know we need to upgrade our current hospitals in order to compete with the private sector for veterans. I know that Audie Murphy, and at some of the veterans hospitals, it does not have some of the minor conveniences that many in the private sector have. For example, private bathrooms, telephones, and, you know, in the private rooms they don't even have televisions.

While this may not be important to the primary care, this is what we are going to be in competition with. How do we intend to upgrade even some of these minor conveniences, and if so how will we pay for it?

Secretary BROWN. We do not consider them minor. The fact of the matter is we are going to be competing with some of the best institutions that look like the Grand Hyatt when you walk into them. We had better have no more than two beds in a room, and we better have private baths, we should have telephones and TV's, colored TV's in the room, and we are going to do that. I think the funding stream that has been made available to the President's initiative that I mentioned to you will allow us to pay for that.

That is where this committee and the Congress is going to be so helpful, is that we must be able to maintain the appropriation that has been provided to us in addition to these other funding streams that will come to us through the alliance and third party insurers. If we run into a situation where we are going to be reduced on the appropriation side because we are getting additional monies from other sources, then you are putting us at a disadvantage and we will not be able to compete and we will be setting the stage for failure.

Mr. TEJEDA. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you.

Mr. Ridge.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman.

Mr. Secretary, it is good to be in your company. I know soldiers from time to time are asked to do some pretty difficult things; from time to time to go out without the complete military intelligence they need to complete their mission, or maybe even the requisite backup to complete their mission. I think you have been asked to do a very tough thing, and that is to come up here and be an ar-

ticulate spokesperson for a complicated health care proposal which includes the integration of the VA health care facility, without the specific document everyone is anxious to see, and I think you have done a very, very commendable job.

One of the concerns that I think you have detected from some of the questioning from my colleagues is the use of the word independent as it relates to the VA health care delivery system. It seems somewhat at odds with the number of new external pressure points on the VA system that are going to actually directly control what the VA does and does not do.

I mean historically the VA has been autonomous. Historically, you came up here with a budget. Historically, you did your own R&D determination. Historically, you made your own independent contracts with other service providers. Historically, independent VA meant independent VA. Now, under this proposal, VA will be interfacing with a health alliance. Now you will have somebody else telling you what has to be in the basic benefits package. Now you are going to have HHS telling you this, DOD telling you this.

I am just wondering if it would be easier, in our consideration of the future integration of the VA into the national health care system under the President's plan, to abandon the word independent, because it doesn't seem like the VA health care system is going to be independent anymore, and talk more in terms of a shared responsibility of the President's health alliances and the VA. You are not going to be independent anymore, are you?

Secretary BROWN. I think so. For instance, you mentioned that we will—I don't know if you meant that, maybe I didn't hear you correctly, that we won't be coming up here to ask for additional appropriations.

Mr. RIDGE. Oh, you will be asking for appropriations.

Secretary BROWN. We will still come up here asking and begging for appropriations. We will still be performing our own R&D. We will still be contracting for services. All of that will remain.

One of the things that I think is essential is that we remain independent, but it is also essential that we be a part of this national health care reform. In the beginning, there were those who suggested that maybe we ought to just leave the VA alone, just allow it to continue to do business as it has done for the last 15, 20 or 30 years. But if we did that, as we move toward national health care, the VA would be out there by itself and it would die.

There would be absolutely no way in the world for it to be able to compete once all of these alliances—I mean the smartest people in the entire country, with all of the resources that are available to them, forming different kinds of contractual arrangements and forming into networks to provide care in any given area, and then you have the VA standing out there coming up here every year getting just enough to get by, it would just absolutely be a ticket for failure.

I think this particular approach will allow us to maintain our independence. It will allow us to continue to come up here and ask you to help us out through the appropriation process, and it allows us to see a massive number of other funding to come into the system to allow us to do whatever we need in order to be competitive. So I think this is going to work real well.

I might add that the guts of this program, the basic structure, was designed and conceived by the national service organizations. This was their idea. I just happen to be the messenger. Although I was in the room at the time it was conceived, I happen to be the messenger here, and I think, quite frankly, that it will work.

Obviously, this is a broad outline. This is a concept. As we get more and more details and we get them up here, we are going to get more guidance and counsel and direction from this committee and the Congress. I think, in the end, we are going to have a good package.

Mr. RIDGE. Thank you, Mr. Secretary, I appreciate the fullness of your answer.

The concern was also expressed by a lot of my colleagues of the special needs of the disabled veteran, service-connected disability and otherwise. And if one of those men or women would opt for a private plan, one of the concerns I have is that the basic package of benefits included in that private plan might not provide the special services that the veteran might be able to get strictly in the VA health care delivery system.

Could you respond to that concern of mine? Because we know the basic package will be designed to meet generic needs of a general population, but the disabled veteran is a very specific population with very specific needs. How do we know that the totality of health care that that particular veteran needs would be provided in a basic benefit package?

Secretary BROWN. You must be a lawyer because you are asking the right questions.

What we will do, if a veteran elects to participate in a private plan and that veteran is entitled to services or benefits over and above the private plan, he can actually just switch over and get those services free for no additional cost. So they are there.

Let's take for instance some benefit that may be the result of exposure to Agent Orange. If he or she is enrolled in a private plan but they would like to take advantage of this benefit as a result of their exposure to Agent Orange, they can come right on over to the VA and get that benefit at no additional cost.

Mr. RIDGE. Good. Very good. You have that base covered, and, again, we will work out the logistics of that at some future time.

Mr. Chairman, I do have several additional questions, but I do have to leave and I would ask unanimous consent to submit them to the Secretary and his staff.

Mr. ROWLAND. Without objection all Members will be able to submit questions for the record.

(See p. 196.)

Mr. RIDGE. Thank you, Mr. Chairman.

Mr. ROWLAND. I recognize the gentleman from Illinois, Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, if I understand the line of questions that Congressman Tejeda raised, you do have a strategy for unfolding a particular alliance on outpatient clinics and so forth, unfolding those resources to attract people to come into the program so we are not only dealing with the operative details of how this plan is struc-

tured but an attempt by the VA to gear up for the influx of veterans; is that correct.

Secretary BROWN. Yes, sir.

Mr. EVANS. Have you ever figured out just how many veterans will have to come into the system to support the 171 hospitals?

Secretary BROWN. Let me answer that in two ways: We are right now working on a model and working on a system that will allow us to predict with some reasonable probability what to expect into our system and from that we can extrapolate exactly what is needed in order to maintain a profitable and efficient operation.

But let's just talk about if we did nothing under this plan—basically, on day one, in a lot of our facilities we just start off at nothing, because what will happen is that we are treating our—and a lot of our hospitals are at capacity because we have closed down certain features in it—but we are treating our service-connected and our low-income veterans in those facilities. Because of the rich features of the plan, for instance, those with low income and service-connected veterans, they will pay absolutely nothing for their care.

If they chose to opt out of the VA system to go to another plan, then they walk away losing 20 percent right away.

But we think because of the additional specialized services and benefits, because of the economic incentive, we will have what we like to think is a core group of people that will keep our system afloat and will allow us to expand as we gain new information and new experience as we begin to implement nationwide health care reform.

Mr. EVANS. There is the concern about what happens if the VA fails to attract those people but there is also a concern they will attract too many people. I understand that within the President's proposal there is a provision in which veterans hospitals can be closed off, basically, and then the care that would be rendered would be given on a priority basis to service-connected. Is that not part of this plan?

Secretary BROWN. I have not heard that.

Mr. RAYMOND. That is a new issue that is not in the plan.

Mr. EVANS. Let's say in Chicago, because I think you will see probably a lot of veterans going into those core area hospitals, if they become overutilized because of the fact of the unemployment we have had and so forth, and even people in marginal jobs might opt out to the VA, are we going to be in a situation or see any situations in which a non service-connected veteran who might have a spinal cord injury wanting to go to the VA because of their excellent record in dealing with this issue would have problems where they in effect would be denied VA health care because of a priority?

Secretary BROWN. Well, obviously, that is a good question to ask, but we do not have any experience with that. I think as we gain more and more experience—and I have to say this here. One of the things that we have at our command is the ability to contract out. Obviously, it is to our advantage to use existing resources, our own structure, because it is much more efficient. We have everything that we need in order to do the job. But because we have an obligation to provide this full comprehensive list of services, we can do that through contracting out.

So we have some mechanism in place that will allow us to be flexible as we begin to expand our system but I think that expansion is going to be an orderly expansion. That is one of the reasons why I refuse to even look at talking about allowing other than veterans into the system. I want to see how many veterans come into the system before we talk about dependents or expanding the system to any other category of people. Once we get the experience there, then we can say, okay, we have excess capacity here, how do we want to fill it.

One of the beautiful features about the President's plan, we could say, "Okay, we want more veterans in this hospital, so what can we add to our specialized list, our supplemental list?" We might say we want to add dental care. So, in other words, the veteran continues to get this whole comprehensive list that is available to all Americans, plus access to all of the other things that we have, plus dental at no cost. That will act as a marketing catalyst to attract new people.

So there are some things that we can do to control who comes to us and who will not, and that is why I want to keep it based on experience as opposed to opening this thing up to everybody and then on January 1, 1994, 1995, or 1996, we will open our doors and we have promised something that we cannot keep.

Mr. EVANS. Thank you. I think the selling begins now. I am going to be holding a hearing on timeliness at VA outpatient clinics this month sometime, and the whole issue of women veterans I think is going to be important as we gear up. We have to start selling the VA now I believe, so appreciate your work and, Mr. Chairman, thank you for your time.

Mr. ROWLAND. Thank you. Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being with us here today. I think a lot of our discussion here today has come around the viability of the VA and insuring that the VA health care system is a viable one that can compete with these alliances, as you described them, that will be bringing together the finest and the best that we have to offer.

We have a recent Inspector General's report which wasn't very flattering on the VA and women's health care, and it is still on my mind and many people's minds here in the United States and it suggests that we need to take dramatic steps in order to ensure that women are adequately taken care of within the VA.

And given the fact that the VA is preparing its office, you have outlined here to us this afternoon, to compete for each and every potential user of the VA system, each and every veteran, regardless of gender, I guess the question I have is, can we imagine that a woman would choose the VA if her main concerns, and we understand that women between the ages of 18 and 50, one of their main concerns in health care is gynecological and pregnancy-related care. Is this something that you envision being in the VA health care scope?

Secretary BROWN. Absolutely. We—I agree with you. Your observations, everything that you said, we do agree. We have not done a good job, and I don't actually blame anyone.

It is something that kind of evolves in an institution that is predominantly male. The women veteran population has remained stable, somewhere around 4 percent, but all we have to do is look at those in the military, we know that once they are discharged, it is going to increase.

So we need to be doing the right thing, and even if that were not the case, we need to do just the right thing. There is no reason why we should be providing goods and services to men and not make those same goods and services available to women who also served honorably.

I might add that in addition to setting up our coordinators in our hospitals and setting up task forces, we set up three national women hospitals—I think it is three or—not four.

Dr. FARRAR. Yes, three, but there is another one in Pennsylvania that is being established as a consortium of hospitals.

Secretary BROWN. Okay, all right. We are doing that, but at the same time, I can say to you this: Women that have concerns about OB-GYN and because we do not have, in most of our facilities, we simply do not have enough women to justify setting up the various specialist operating rooms and so forth, but the VA would contract it out and pay for it so they are not disadvantaged at all.

If it is our responsibility to take care of our gynecological problems, we will do that in the private sector and we will pay for that service, and at the same time, we are moving forward, gaining more and more experience on how we should respond to the very sensitive needs of our female veterans.

Mr. GUTIERREZ. Thank you very much, Mr. Secretary. Just to share, it comes from probably a very personal experience of one time, Sister Stella Louise who runs a hospital, Saint Mary's in Chicago, runs it very well, asked me, what do you think we should be doing, and I had just—my wife had just given birth to Jessica, our second daughter, and I said to her, you know, I would open up a place here that attracts women because it was my experience that I was even going to the primary provider of health care because it had changed.

It had changed when my wife had picked up a new doctor to—as she became pregnant, as she gave birth. All the prenatal care and all of the direction and all of the post-natal care that came with that child, with any child that gets colds, and then I said, well, why don't I just go to the same place, and really my wife made those kinds of determinations, and it seems to me that given the increase in population of women, both those that have been discharged and the potential in increasing numbers, that if we are going to compete with all of the other sectors, I kind of think my story might get repeated time and time again, that a woman is going to give birth to children, is going to be in need of gynecological and obstetrics, and then where is she going to get them? Of course, I think she is going to bring the rest of the family along with her.

I wanted to share that story with you and thank you for listening, and I look forward to working with you, Mr. Secretary, and please call upon this servant to help you in the process.

Thank you, very much.

Mr. ROWLAND. The gentlelady from Florida.

Ms. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, first of all I want to commend you for your leadership in instituting the program putting veterans first.

I think that answered Mr. Applegate's questions pertaining to how we treat our veterans and I think that is a very good program. As you know, there is a well documented need in Florida for another VA outpatient clinic and VA nursing home.

In fact, the VA is scheduled to build several new facilities in the State of Florida in the years ahead. Under the President's National Health Care Reform Plan, does the VA still plan to build a VA medical center slated for Brevard County and a VA outpatient nursing home slated for Orange County?

Currently will the VA be pursuing an ordinance to building new facilities, such as joint ventures with DOD or the transfer of facilities scheduled to be closed in Florida and the rest of the country?

Secretary BROWN. I will say, Ms. Brown, on your question regarding the nursing home in Orange County, we intend to continue to pursue that issue.

As you know, we are looking at possibly acquiring the naval hospital that is there. We are working very, very hard on that because we have identified that area as needing that facility to include an outpatient clinic in that area.

With respect to the hospital center in Brevard County, yes, ma'am. We plan on following up on that too. That is an issue that is on our agenda, and I would like to see that hospital built by 1999. I want to make sure, is that 1999 or 1997?

Dr. FARRAR. Finished by 1999.

Secretary BROWN. 1999, yes.

Ms. BROWN. I could have some more questions, but I will just wait.

Mr. ROWLAND. The gentlelady has some additional time, if she wishes to ask a further question.

Ms. BROWN. I will just pass at the moment.

Mr. ROWLAND. We have covered everyone.

Mr. Secretary, I was interested in your remark, comment, a little bit ago that the VA would die if it was not part of one of the health alliances.

I would like you to expand on that and like to understand more why you feel that that would be the situation.

Secretary BROWN. Maybe I misspoke. I did not mean to say that the VA would die if it was not part of the health alliance. I view health alliance as an entity within a defined geographical area.

I think, in some instances, that we could survive there. What I intended to say, that I believe the VA would die if it were not part of the President's national health care reform effort, and the reason for that is that all these other organizations are going to be able to come together, pool their resources, streamline their operations, and take advantages of all of the modern techniques and advances that have been made in medicine, in particular in ambulatory services and so forth.

The VA, because of its poor funding structure, will not be able to keep up with it. It will not be able to do all of these things. For instance, I was just in North Dakota and it bothered me a lot when it was a beautiful campus setting there in Sioux Falls, and I went

into one of the wards and it had six beds centered and there was a community bathroom at the end of the corridor.

Now, to my way of thinking, if a veteran has a choice, he or she is not going to select the VA, even though we have—there is a lot of demand out there right now. But if they have a choice, then I would think that we would have a difficult time competing under those arrangements.

So because of the resources that are made available to us, we will not be able, for instance, to bring that infrastructure to renovate that whole hospital there so that we can have a modern hospital that will be able to compete with the other two hospitals that are in that town.

So that is basically what I mean, and that kind of an overall sense permeates all across the spectrum.

Mr. ROWLAND. Do you think that if the VA, as it now stands, had those additional funds that it will get if it becomes a part of an overall health reform plan, that it would be able to do the things that you are talking about without becoming a part of that plan, if it had the medicare, if it had the insurance, if it had these other funding streams coming to it, as you stated so eloquently earlier? the VA has been pushed against a wall for 10 or 11 years now, not getting the funds that it needed to get in order to provide what we believe is the quality care that veterans are entitled to.

You don't think that the VA could still stand alone if it had these additional funds and be competitive with any system that is put in place with national reform?

Secretary BROWN. I would be very—I would hesitate to answer that in the affirmative because with all due respect, the funding source that we have had over the years has been very shaky, very, very shaky. We have never had a stabilized funding source to be able to do what we needed to do.

You take, for instance, Ms. Brown raised a question about some of the areas in Florida. The fact of the matter is, Florida has one of the largest growing populations in the entire country. If we had the proper funding mechanism, we would have already had our infrastructure in place to be able to accommodate that.

We were able to project many, many years where the veterans were moving to, a net of approximately 3,000 a month. So we knew that that was going to happen. But because of this unstable funding source and all of the political considerations that have to be taken in place, it places at risk what an organization needs to do in order to be responsive to the needs that have been identified.

Mr. ROWLAND. It is not clear to me why the funding source would be any less shaky if the VA system was rolled into this national health reform system.

We have already talked earlier about some of the uncertainty about funding that would be coming. So, it is still not clear to me why it would be any less shaky under being rolled into it.

Let me just make this comment. I recall in 1974 when the National Air Planning Resources Development Act was passed that there was an attempt at that time to roll the VA health care delivery system into the overall scheme that was taking place, and there was a real fight at that time.

I am a little uneasy that it is possible that somewhere down the road that kind of attempt will be made again.

Secretary BROWN. Well, I don't worry about it too much because I know as long as you are Chairman and you are in the position that you hold, you are going to make sure that that does not happen.

I think, as everyone recognized, the ultimate decision on what and how this plan will look would be based on the reactions and the considerations that are applied as a result of this body.

But let me go back to the first question that you raise about a stabilized funding source. I think there is a big difference, and the difference is that we will get paid for every veteran that is enrolled in our system. That is part.

That money would come in from the alliance for every veteran—basically for every veteran that is enrolled in our system. That is a consistent funding source and we do not have that kind of situation under the present situation.

Mr. ROWLAND. I may want to come back while the light is not on, I am sure I have used more than 5 minutes. The gentleman from——

Mr. SMITH. Thank you very much, Mr. Chairman.

Mr. Secretary, you pointed out earlier that the self-employed service-connected veteran will not have to pay for health care, and obviously that was passed on, I am sure, some hard data.

How many self-employed veterans fit into that category, and how much loss of revenue are we talking about potentially?

Secretary BROWN. This was a decision that was just made and concurred by the President within the last 24 hours, and we are in the process of trying to crunch those numbers.

Mr. RAYMOND. We are using several sources. We are working with our small business program in the VA with the 1990 census data and our own survey of veterans, and we should have that very shortly.

Mr. SMITH. With all due respect, the decision was made before the numbers were crunched and available?

Mr. RAYMOND. We made an assumption when the Secretary and the President considered this, having looked at the proportion of self-employed Americans, the principle of service-connected veterans getting special treatment, really carried the day as opposed to a funding consideration.

Mr. SMITH. If we could have that information, it would help in our deliberations.

Secretary BROWN. Mr. Smith, I would like to just say that I think you are right. We made that decision before we had the numbers, but I think that in and of itself speaks to the commitment of this President, that he has a special understanding and feel for the commitment that the Nation has to our service-connected veterans, and I think that was reflected in this very courageous decision.

Mr. SMITH. Along the same lines, employee benefits, including health care insurance, are recognized to be a part of a compensation package in lieu of salary.

In that sense, under the President's health care plan, isn't it true that it would actually be the employee service-connected disabled

veteran and not the employer who would be relieving the government of the cost of his or her health care?

I am sure you follow what I am saying, that for many employers, they look at the benefit side, not the salary side, and since there is a 20 and an 80 percent kick-in from both employer, employee, I can clearly envision employers who will say, we are paying your health care and you are service-connected disabled, but we are paying your health care, and that salary hike that you were hoping for will not occur next year or the year after or whatever or not today. So it is part of a salary package.

Secretary BROWN. Well, you may wish to consider that, but the fact of the matter is that for a large part, that is what has taken place today. Most Americans that are service-connected, they have health care packages.

Mr. SMITH. Except for the service-connected disabled veteran utilizing the VA today when he walks in, he or she can get care without contributing to that care.

Secretary BROWN. Yes, but that will continue under the President's plan. Let us maybe simplify it a little bit by taking a service-connected veteran, let's say he is missing an eye and that is 40 percent, and he works for IBM. He has a heart attack and he, for whatever reason, under today's criteria, he wants to go into the VA to receive his care, but because he is an acute situation, he can't go to the VA.

Then the VA turns around and they bill IBM for his care. That is what can take place today.

Mr. SMITH. Okay, health insurance is part of the salary. Let me ask you a question along the lines of an issue that was raised in this subcommittee not so long ago and I know you are familiar with it.

As part of the basic package, it is my understanding that the Administration plans on promoting abortion on demand. It is unclear whether or not they will have specific language that says that or they use some of the words that would, as a consequence, mandate that.

As I think you probably know, there isn't a single poll that I know by a reputable organization, including the *New York Times* and the *Washington Post*, that shows any mandate whatsoever from the American people for that kind of inclusion.

As a matter of fact, the *New York Times* found that only 23 percent of the American public want abortion as part of the basic package. Other polls are similarly right up there with 70 or 75 percent of the people saying they don't want it in there.

We are talking about competitiveness. Leaving aside the ethical issue of taking the life of an unborn child for any reason whatsoever, which I think ought to be the driving issue. Let's talk about the competitiveness issue. When there is no public clamor for something, and as a matter of fact, with this issue the chorus of voices is going in the opposite direction, it is inconceivable to me that the Administration feels that this is something that is going to make the VA or anything else more competitive.

I would appreciate your views on this issue, if you could.

Secretary BROWN. Well, first of all, I am not sure of exactly what position that the national comprehensive standardized package would contain with respect to abortion.

Mr. SMITH. Could I interrupt briefly one second, Mr. Secretary? In your answer, is it your view that the VA ought to take the lead on this or do you want to leave it to the National Board or Congress to decide the basic package offered by VA?

Secretary BROWN. It is my view that we will provide the basic standardized package that is adopted by the national board or that is adopted by the National Health Care Reform initiative.

Mr. SMITH. You wouldn't want the VA taking the lead in providing for abortion coverage?

Secretary BROWN. It is my view, whatever package that is defined in a national reform initiative, that is the package that we will offer as a standard package to everybody that is enrolled in our system.

Mr. SMITH. Thank you very much, Mr. Chairman.

Secretary BROWN. Yes, sir.

Mr. ROWLAND. As I understand it, under the President's plan, only high income veterans, if they are medicare eligible, pay; is that right?

Secretary BROWN. Yes, sir.

Mr. ROWLAND. Well, about one-third of our inpatients are medicare eligible now and many of those come from the lower socioeconomic strata and are not high income people. How many of these will the VA be paying for?

Secretary BROWN. The VA will pay for all of our lower income veterans, all of them. We will not ask nor request reimbursement from the medicare trust fund to offset their care.

We will only ask for reimbursement from those high income medicare eligible for reimbursement.

Mr. ROWLAND. Why would you not ask medicare to pay for all veterans who are medicare eligible?

Secretary BROWN. Well, it was the basic feel that the government had a statutory requirement to provide care to two categories of veterans, our service-connected and our lower income, so what the whole philosophy was, let's kind of grandfather them in and let the government continue to provide the funding that is necessary to provide them with quality care.

In addition, under the present program, we did not want to cause any additional outlay of funding from the medicare trust fund. The people that we are going at right now, these high income medicare eligibles, they are already spending their medicare dollars in the private sector.

We are simply saying, we want you to spend some of that money with us. Now, that does not cause an additional dollar to be drained or offset from the trust fund. If we applied that same rule to our low income veterans, it would have cost the trust fund some additional funds, that was a balance that we were looking for, and we felt that that would be fair.

Mr. ROWLAND. Do you envisage that with the reform that is being talked about now for the VA that we may eventually not have any categories of veterans?

Secretary BROWN. Well, I would like to think that there will always be a category of veterans. Quite frankly, one of the concerns that we have all had, and I think I am very pleased that I was able to announce at this particular hearing, that the President has recognized sacrifices that have been made by our service-connected veterans.

So I would hope that we will always have some kind of label that will describe the people who have made sacrifices in carrying out the policies of the United States Government.

Mr. ROWLAND. Let me ask you something else on a different note. It is anticipated that it is going to take about $1 billion to get some infrastructure in place to participate in this reform. Is that not the estimate that has been given?

Secretary BROWN. We are working on that figure now. We, obviously, as soon as we get that together, are going to be coming to this committee on our knees hoping that you will give us some relief that will allow us to get the necessary funding to make this investment in America's veterans' future.

Mr. ROWLAND. Well, you know that this subcommittee and the committee in general has always been supportive of giving the kind of money that is needed, but the problem has not been with the authorizing committee, it has been with OMB.

Secretary BROWN. Right.

Mr. ROWLAND. You anticipate we won't have that kind of problem now?

Secretary BROWN. I don't anticipate anything in this climate. I am going to react based on experience.

Mr. ROWLAND. You haven't at this point asked for the money for the 1995 budget.

Secretary BROWN. No, sir, we have not. We are still working on the numbers. We are trying to get a better feel for exactly what is it that we need, do we need to respond immediately.

As Ms. Keener mentioned, we need to get some legislation changed that will allow us to gain some experience from setting up these, for lack of better terms, microcosms out in the various States that we expect to come on line fairly shortly.

Mr. ROWLAND. If you don't, don't you think you might be running behind in order for to you move as expeditiously as possible?

Secretary BROWN. Yes, sir, that is why we are working on it and we are going to be working very, very closely with you, sir, to expedite our requests so that we will be able to respond when these States, particular States like Washington, become ready to start their health care initiative.

Mr. ROWLAND. Gentlemen from New Jersey.

Mr. SMITH. Thank you.

Did you want to go again?

Ms. BROWN. Yes, I just have one follow-up.

Mr. SMITH. Sure.

Ms. BROWN. Just a follow-up. I know that most American women, including women that rely on their OB-GYN as their primary source of health care, in the President's health plan, including pre-family planning services and pregnant-related services, how does the VA plan to provide women veterans with these services?

Secretary BROWN. Ms. Brown, if we are unable to provide those services in-house, we will contract those services out to other providers in the alliance.

Ms. BROWN. That is it, Mr. Chairman.

Mr. SMITH. Mr. Chairman, I would ask unanimous consent that some questions by Mr. Buyer be posed to the Secretary for the record, as well as some other questions that I have. I will ask two very brief final questions of the Secretary.

Mr. Secretary, the independence of VA is something that concerns many of us, and I am sure with diligence it can be maintained, but how, with a national alliance or a National Board dictating what it is that the VA provides or doesn't provide, and with other non-VA agencies having oversight and input, can that essential character of VA that we have all known as a very independent network of health care focused exclusively on our veterans be preserved over time?

In addition, I would like to point out what happened in Canada where the VA system was unfortunately done away with. Though I am sure that was not the intention of the Canadian parliamentarians when they enacted those reforms back in 1968, the VA as an independent health care system disappeared, nonetheless.

What assurances can you give us that 10 years from now, assuming this plan passes, that the VA will be the independent organization that we have come to respect and fund every year?

Secretary BROWN. The best assurance that I can give you, obviously I am not clairvoyant and I cannot see the future, but the best assurance that I can give you and what I have to sustain me is when we have people like Ms. Brown and yourself and the chairman serving in important positions like this in the Congress of the United States, I think when we have folks like that that are dedicated to the cause, that understand the sacrifices of our veterans and appreciate those sacrifices, and you combine that with the collective strength of our service organizations, organizations like the DAV, the American Legion, PVA, AMVETS, just all of those kinds of organizations, if they stay behind this process and we continue to elect a President like Bill Clinton, we can't go wrong.

Mr. SMITH. I appreciate your kindness and I certainly have a great deal of respect for you. I am concerned that when this whole issue leaves the Congress, say it passes pretty much intact as the President envisions it, that a Supreme Court-like independence that this National Board is likely to assume or Federal Reserve-like board independence, then those of us who are unhappy, as we are often unhappy on this committee with what the OMB or what our appropriators do, despite the best of intentions, we may find ourselves up against a very stacked deck. Then when rationing potentially kicks in, because the board sets limits—aggregates after which reimbursements or funds will not be available—I am extremely concerned that the spinal cord veterans, those who have catastrophic concerns and needs, may get short changed as it becomes apparent over the years that more and more of our VA hospital administrators have to be competitive. I am also concerned that over time, competitiveness will replace our concern about providing quality care to those who need it the most, the spinal cord veterans and others like them.

Secretary BROWN. Let us just take your example. Our spinal cord injury unit would continue to fall under the purview of this committee. It will be funded through appropriated funding.

So I don't see that as a problem. I know you would not allow that to happen. I really—and as far as the board, obviously if we are beginning a journey here, it is a journey that needs to take place, and I think that as we move forward, we will all gain from that experience, and then we can use those experiences to respond to some of the issues that you raise.

But I would like to take that approach as opposed to trying to project based upon a lack of information of what would happen on what ifs.

Mr. SMITH. Just one final note, then I will yield back the balance of my time. I do remain concerned. This committee has made very hard and painful choices when reconciliation rolls around.

We look for every way to avoid cutting the medical budget. If the problems and the exacerbating problems within our budget continue with interest outpacing just about everything else in terms of its rate of growth as a line item within the budget, despite every intention we may have, I am concerned that over the long run, we may have a very hard time providing those funds, especially if competitiveness becomes the marching order.

Secretary BROWN. I think your comments actually in my view justify the reasons why we have to do this. I think, as a people, as a society, we simply can no longer continue to spend over $800 billion a year and at the same time have 37 million Americans uninsured, 22 million underinsured.

We cannot allow the average family by the end of this decade to pay $10,000 for their health care. That is outrageous. We cannot allow, when the inflationary rate is about 4 percent, we have an increase of health care at 14 percent and that is projected to be nearly 20 percent by the end of this decade.

We cannot allow in just 4 years where $1 out of every $5 that Americans earn will be spent on health care. We have got to get this under control, and I think that this is the best solution, best thing since suspenders.

Mr. ROWLAND. I appreciate the Secretary's remark that we do spend 14 percent of our Gross National Product on health care.

We must get it under control, so it is really odd to me that the Administration is proposing increasing taxes to fund the system that they want to put in place. It seems to me that we will reach that 20 percent level before the turn of the century.

If there are no further questions, I want to thank all of you for being here today and thank you for your patience in waiting on us while we had to go and make votes. Appreciate it. We stand adjourned.

[Whereupon, at 4:42 p.m., the subcommittee was adjourned.]

ROLE OF DEPARTMENT OF VETERANS AFFAIRS IN NATIONAL HEALTH CARE REFORM

THURSDAY, NOVEMBER 18, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (Chairman of the subcommittee) presiding.

Present: Representatives Rowland, Long, Tejeda, Bishop, Kreidler, Smith of New Jersey, Stump, Bilirakis, Buyer, and Linder.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. Good morning.

This morning's session continues a process we began in April when we convened a hearing to identify the principles that should govern any VA role in a national health care plan.

Most recently, on October 14, Administration witnesses appeared before this committee to outline the President's plan for the role of the VA under the proposed Health Security Act.

Undoubtedly, the diversity of views regarding the President's health reform bill is reflected among the membership of this committee. Our challenge, however, is to set these differences aside and to work to ensure that whatever national health care legislation may emerge from Congress serves veterans well and preserves the strengths of the VA health care system.

We are fortunate today to have an array of witnesses who reflect the views of consumers and providers of VA health care as well as the perspectives of America's medical colleges which have long been valued partners in assuring high quality VA care.

Those at the witness table all have a critical stake in VA's future. I have reviewed their testimony and believe their insightful analyses will help us in the task ahead. That task is not simply legislative in nature. The national health care reform debate has dramatically accelerated VA work on long needed reforms.

However, as several of our witnesses have suggested, VA must reform its health care system whether or not the Congress adopts the President's legislation. I believe such reforms must build on

VA's strengths, discard that which inhibits streamlining and efficiency, and free VA facility managers to manage.

Whether or not VA becomes a marketplace competitor, this committee will play a critical role in encouraging and overseeing the process of reshaping or reinventing VA health care. In the months to come, today's hearing will certainly provide an important touchstone to the vital legislative oversight task before us.

Before I recognize the ranking member on this subcommittee, I would like to recognize and pay tribute to a valued member of the staff of this committee. This is our last hearing before Barbara Daniels retires. Barbara has served as a staff member of this subcommittee for 24 years.

Barbara, we want to thank you very much for your years of dedication to our veterans. Thank you very much. (Applause.)

Mr. Chris Smith.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH of New Jersey. Thank you very much, Mr. Chairman. I want to join you in congratulating Barbara on her excellent work.

You know, one of the things that this committee is known for is its bipartisanship, and that is not only among Members but equally among staff members, so I want to thank you, Barbara, for your good work on behalf of veterans for these many years.

Mr. Chairman, once again this subcommittee takes up the weighty question of the role of the VA within national health care reform and in particular the President's Health Security Act. This hearing today has a constructive purpose—to help ensure that any legislation we approve will provide our veterans with the highest quality health care the VA can offer.

In addition, the committee needs to be sure that health care reform of the VA is faithful to the nine-point agenda this subcommittee approved earlier this year.

Mr. Chairman, I am pleased that the testimony today reflects some of my concerns and yours as well, and I am especially pleased that we are reaching a consensus on which questions need to be asked. I certainly agree with you, Mr. Chairman, that there are a diversity of views on how to approach this issue, but we all agree that we must ensure that any national health care plan meets the needs of our Nation's veterans.

Mr. Chairman, I have many concerns about the Health Security Act as proposed by Mr. Clinton, such as shifting the burden of paying for the care of service-connected disabled veterans from the Government to the private sector. I also have questions regarding the future of an independent VA when its package of basic benefits and virtually its entire function is overseen by a national board rather than our elected leaders. I also have concerns about what would go into that basic benefits package.

I hope the representatives of the major veterans' organizations, who are highly qualified individuals and whose counsel is invaluable to this subcommittee, can help us answer these and other questions that we have, and I would ask, Mr. Chairman, that my full statement be made a part of the record, and I look forward to the testimony.

Mr. ROWLAND. Without objection.

[The prepared statement of Congressman Smith of New Jersey follows:]

PREPARED STATEMENT OF HON. CHRIS SMITH

Mr. Chairman, once again, this subcommittee takes up the weighty question of the role of the VA within national health care reform and in particular the President's Health Security Act.

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Mr. Chairman, I have many concerns about the Health Security Act such as shifting the burden of paying for the care of service-connected disabled veterans from the Government to the private sector.

I also have questions regarding the future of an independent VA when its package of basic benefits and virtually its entire function is overseen by a National Board rather than our elected leaders. I hope the representatives of the major veterans' organizations who are highly qualified individuals and whose counsel is invaluable to this committee can help us answer these questions. We need their help in plotting a course for the VA's future.

Now is the time for veterans and veterans' advocates to come forward with their concerns. It is my hope that this subcommittee will hold more hearings on this complex subject early next session which will address specific legislative language. It will be too late to protest once some model of health reform is adopted. I strongly urge the witnesses the help this committee shape a responsible package which will serve the needs of our Nation's veterans for years to come.

Mr. ROWLAND. The gentleman from Arizona, Mr. Stump.

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman. I have a statement, too, that I would like to make.

Mr. Chairman, let me just say that I do not support the Health Security Act as it applies to the country in general and have serious concerns about its impact on VA health care.

Even before the legislative draft was made available, a lot of support was given to the plan by the veterans community. Now this kind of disturbed me, especially having seen some of my early concerns about the plan borne out by the proposed legislation.

These concerns continue to include whether we should shift the financial responsibility for service-connected care from the Federal Government to employers and ultimately to the veterans themselves.

How can the VA be truly separate and independent under a national board and all the new policy bureaucracy envisioned by the President's plan?

Can the VA survive in a totally unfamiliar competitive environment, with extremely efficient private sector providers?

Will the VA be able to attract veterans when the basic benefit package offered by VA to veterans is the same as the basic benefits offered to people who did not serve in the armed services?

Will the infusion of Medicare dollars and other funds simply be offset in budget process and not provide a big boost to veterans' access?

What if the VA can't compete? Does it cease to exist? On this, the Health Security Act is ominously silent, and that disturbs me even more.

I would like to welcome all the witnesses here today, and I hope we will have a frank discussion on the future of the VA in a national health care reform scenario.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you very much.

Mr. ROWLAND. Our first panel of witnesses consists of Dr. Marvin Dunn, who is Dean of the School of Medicine, University of South Florida; he is representing the Association of American Medical Colleges; and Dr. Thomas L. Garthwaite, who is President of the National Association of VA Chiefs of Staff and Chief of Staff of the Zablocki VA Medical Center, Milwaukee, WI.

Gentlemen, thank you very much for being here this morning. We would ask that you limit your oral statement to 5 minutes, and your entire statement would be made a part of the record, and you may proceed as you so desire.

Dr. Dunn?

STATEMENTS OF MARVIN DUNN, M.D., DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF SOUTH FLORIDA, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND THOMAS L. GARTHWAITE, M.D., PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF STAFF, AND CHIEF OF STAFF, ZABLOCKI VA MEDICAL CENTER, MILWAUKEE, WI

STATEMENT OF MARVIN DUNN, M.D.

Dr. DUNN. Thank you. Good morning, Mr. Chairman, members of the subcommittee.

I am Marvin Dunn, Dean of the University of South Florida College of Medicine, and I am here today on behalf of the Association of American Medical Colleges. We greatly appreciate the opportunity to testify this morning on the role of the Department of Veterans Affairs and medical schools in the reform of our national health care system.

Over my 34 years in academic medicine, I have been associated with four different medical schools and five different VA medical centers: Philadelphia, San Diego, San Antonio, Tampa, and Bay Pines. I have been the dean at two medical schools, and therefore I chaired the VA's Joint Deans Committee.

My own school in Tampa is a good example of many of the schools that could not have started, expanded, or flourished without the VA partnership. The University of South Florida opened its medical school in 1971, and the VA opened a new hospital at the same time across the street. The VA has provided us a second hospital in the meanwhile at Bay Pines, 38 miles away. The value of our 22-year partnership of mutual support, high-quality patient care, training and education of health professionals, and medical research is replicated across the country by 102 medical schools that also have affiliations with VA medical centers.

This was the intent of affiliations, as you know, begun by the now famous Policy Memorandum Number 2 in 1946, and I believe it has lived up to its expectations.

Health care reform will impose changes on the VA system and on medical schools. This is a complex issue. We have attempted, Mr. Chairman, in our prepared testimony to identify some of the major interrelated factors, all of which, we believe, must be addressed for a sound decision on the future of the VA.

For example, current eligible veterans now represent an older, sicker, poorer population with more diagnoses per individual than we find in private practice. This means this group will not immediately be welcomed into any private practice grouping because they will represent high risk and high cost.

On the other hand, the VA medical centers and their academic medical center partners have developed special expertise to care for such patients, and this we feel must be preserved. These are such areas as in geriatrics, mental health care, long-term care, spinal cord injury, and limb loss rehabilitation.

Academic medical centers also are dependent on the VA medical centers for training and education for future health professionals. Half of today's physicians have spent some time either as a medical student or resident or both in a VA hospital.

The VA has increasingly learned, with its academic medical center partners and even the Department of Defense facilities, how to share services to avoid duplication and achieve efficiencies. Here we have been, I think, well ahead of our private sector colleagues.

We believe this sharing concept can be expanded under health care reform to permit the development of VA academic medical centers and non-VA partner providers into fully integrated networks while maintaining the integrity of the VA itself. Such an integrated partnership can then compete in the open market and yet retain preferential admission and care for eligible veterans and their dependents, keeping those costs segregated from that of the competitive part with the rest of the community.

We believe, therefore, Mr. Chairman, that when one looks at all of the options open concerning the future of the VA under health care reform, it is through such a fully integrated network of VA hospitals, academic medical centers, and non-VA providers that we can best achieve what is needed.

We believe this can best meet the VA's statutory missions of patient care, health care education, medical research and military medicine support. It would honor the commitments to our veterans, it would honor the commitments to the academic medical centers, it would provide a cost-effective model in health care reform, and it would serve as a basis for research in how to deliver health care in an effective way.

Thank you, Mr. Chairman, for this opportunity to share my views and those of the Association, and I would be happy later to respond to any questions.

[The prepared statement of Dr. Dunn appears at p. 98.]

Mr. ROWLAND. Thank you, Dr. Dunn.

Dr. Garthwaite.

STATEMENT OF THOMAS L. GARTHWAITE, M.D.

Dr. GARTHWAITE. Mr. Chairman and members of the subcommittee, it is a privilege to represent the National Association of VA

Chiefs of Staff and to address this subcommittee on the role of VA in national health care reform.

Both the President's Health Security Act and various State health care initiatives are moving forward. We believe that the proposed role for the VA health care system is reasonable and offers us an exciting opportunity. We believe the VA can perform well under these plans based on our experience in providing comprehensive care within a global budget.

However, there are issues which will need to be addressed immediately for the VA to succeed. Our first concern is that some VA medical centers may start the competitive race behind other providers. Individual States are moving quickly to institute their State health care reform plans. It is unknown how long it will take to pass the Clinton Health Security Act or what the final form will be. It is important that local VA medical centers are allowed to function as accountable health plans in States which are already enrolling patients.

Our second concern is that we will need to be able to provide care for veterans' dependents since many veterans will want to enroll in a family plan. While we are extremely sensitive to the fact that we must not deny any veterans access to VA in order to care for dependents, we feel strongly that the inability to offer care to dependents will deter veterans from choosing a VA plan.

Our third concern is that the proposed methodology to adjust payments to accountable health plans based on the risk of the patient is not well defined. Since the majority of patients that we currently treat are high risk, the methodology for risk adjusting patients will be critical to the survival and success of the VA.

For example, a risk adjustment based only on age and sex will not recognize the fact that veterans who receive their care from VA today are much more likely than the general population to suffer from multiple chronic diseases, mental illness, HIV infection, and poverty.

Our fourth concern is that many of our medical centers have old physical plants which were designed for inpatient care, not outpatient care. Many medical centers also lack amenities such as private bathrooms, private rooms, and bedside telephones.

Price and competition should eventually allow patients to determine the market value of such amenities. But prior to equalization by market forces, VA medical centers will operate at a significant handicap.

Our fifth and perhaps most critical concern is the need to reinvent the VA. A radical and profound change will be needed for VA to succeed under health care reform.

The proposed reorganization of VA regions into smaller veterans' service areas may be a positive step. But we are really talking about a much more fundamental change. The culture of VA must change. The current culture in the VA system is one which inhibits risk taking, encourages excessive paperwork, restricts flexibility, and tries to fix defects by inspection.

To succeed, we must have local autonomy to negotiate with health alliances and to adapt to local market pressures. Marketing of our products via advertising and word of mouth will be vital. We will not survive if we must continue to endure an army of inspec-

tors whose main purpose is to find sporadic defects while ignoring our abundant accomplishments.

We must be able to hire employees we need when we need them without regards to floors and ceilings. We must be able to buy equipment when it is needed rather than condensing those efforts to the end of the fiscal year and overworking our fiscal and acquisition specialists every September.

We must be able to provide incentives to employees for exceptional quality and productivity. We must cease our practice of writing rules and regulations which inhibit change, but rather we must facilitate the implementation of new and improved procedures.

Whether such fundamental change can occur within the current structure is unknown. We have been discouraged by our inability to make even small changes in medical center missions. There may be an advantage to making the VHA a quasi-governmental organization like the Postal Service.

We have been encouraged recently by the direction provided by the Secretary and the Acting Under Secretary for Health, and we have been encouraged by the initiatives under the Vice President's attempt to reinvent government.

Recent studies indicate that the VA provides health care with equivalent outcomes to the private sector at a lower cost. We believe we can continue to provide cost-effective and high quality care and attract veterans who have a choice under health care reform. But if we are to compete successfully, we will need both your support and your trust.

Thank you.

[The prepared statement of Dr. Garthwaite appears at p. 108.]

Mr. ROWLAND. Thank you very much.

I recognize the gentleman from Arizona for questions.

Mr. STUMP. Thank you, Doctor.

Dr. Dunn, should the VA be subject to the same standards as other health care providers? And, if so, can you recommend ways in which we could conform yet maintain our independence?

Dr. DUNN. What do you mean by the same standards? If you mean the same standards of care, I would say yes, or even higher, and I think we meet them at this time. But I suspect you have something else in mind.

Mr. STUMP. Well, I don't know exactly what they have in mind with their bill were it to be included under that.

Dr. DUNN. The question of being able to compete in a marketplace for the same price is going to be the most serious problem if the VA is left out there all by itself, because it represents a group of patients, as I mentioned, that are older and sicker, with multiple diagnoses. They are not going to be welcome in any group, because they will skew the risk and the cost of that group, and therefore I believe we must be very careful as to how we preserve an opportunity in our health care system for these particular patients.

Mr. STUMP. Thank you, Doctor.

Dr. Garthwaite, let me ask you, your testimony states that one option of reform is to allow the VA to provide such specialized services that it has over the years developed special expertise in. Do you believe inclusion of such services is essential to the VA's ability to survive in a competitive scenario?

Dr. GARTHWAITE. Clearly the VA has certain strengths. I think that ultimately how we survive will depend a lot on what the basic benefit packages are and what the supplemental benefit packages are and how those are funded. Ultimately, the decision to choose the VA system will be based on how much it costs out of pocket.

Today we see patients who come to our medical center, even though they have a physician somewhere else that they are also seeing, because the cost of their medications is excessive. For example, if you have a marginal income and your cardiac medicines would cost you $100 to $150 a month, coming and paying the $2 VA copay or getting them for free at the VA is a major incentive. We do have specialized services beyond what the private sector has in spinal cord injury, PTSD, prosthetics and so forth. I think those are things that the private sector might either emulate or buy from us if we were allowed to provide them under contract.

Mr. STUMP. Long-term care, for instance, is not mandated. Should it be?

Dr. GARTHWAITE. I think the essence of long-term care, is: do you have to spend down all your resources in order to have free long-term care?, and, if not, who is going to provide that care? Long-term care in an institution is very expensive, probably $30,000 to $35,000 a year to stay in a nursing home. You start multiplying by a significant number of patients, and you are talking about a lot of money.

So the question really becomes who is entitled to what and who then pays for it when people can't afford it. I think it is an entitlement issue. I think we do a good job providing long-term care to those that have been deemed to be entitled to that care.

Mr. STUMP. Thank you, Doctor.

Mr. ROWLAND. Mr. Tejeda.

Mr. TEJEDA. Thank you very much.

Dr. Garthwaite, you mentioned that VA hospitals in States that are already moving forward with health care reform will have a competitive edge over other facilities. How can VA hospitals remain competitive in States that have not begun that reform?

Dr. GARTHWAITE. I think the force that I see happening is that patients who are, for instance, category A and who are now getting their care from the VA are beginning to get literature that suggests they should choose a health care reform package. The VA is not amongst those packages, so therefore there is a possibility that some of those patients will be drawn from the VA. They may get started receiving their health care from another system and then, if the VA is allowed to compete and offer an accountable health care plan, we will be faced with the need to draw those people away from their existing plan where they have already established a relationship with their care providers. I think that puts us at a disadvantage.

Mr. TEJEDA. We have heard that many capital improvements are needed for the VA to compete with the private sector. As a matter of fact, Secretary Brown was here a couple of weeks ago, and basically the same question was asked, and we said, "How are you going to compete with the private sector when, in fact, some VA hospitals have no private bath and other private facilities?" What are your thoughts on that, or how can the VA compete?

As a matter of fact, he said at that time that with our rehabilitation program or our improvement program, the VA will be able to compete, I think, with the best Hilton hotel. You may have heard that, and I would like to hear your comments on that.

Dr. GARTHWAITE. I think that the physical plants, the hotel amenities of going into a hospital, are part of the picture. I don't think that they will overcome a significant copayment or the need to pay for prescription medications. I think it is part of the equation.

If a veteran has a choice between going to a private hospital, with no copay, and with a private room with a private bath and a bedside telephone and a VA medical center in which he shares a bathroom and has no telephone, then the amenities will become a significant part of the equation.

I think in contrast, if there is a copay in the private sector and you get additional benefits in the VA, a veteran might choose the VA. So I think the physical plant and hotel aspects are part of equation, but I think how much a part of the equation will vary with the specifics.

Mr. TEJEDA. Thank you very much, Mr. Chairman.

Mr. ROWLAND. Thank you. Dr. Linder.

Mr. LINDER. Thank you, Mr. Chairman.

Dr. Dunn, on two occasions you have said that these people with multiple diagnoses would not be welcome in some of these purchasing alliances, and yet it is my understanding that the Clinton health care plan is predicated precisely on not excluding anyone. Isn't that your understanding?

Dr. DUNN. Yes, sir.

Mr. LINDER. Why would they not be welcome?

Dr. DUNN. Because if I were setting up such an alliance and these people were to be included, they are going to be very high cost individuals. If you are running an alliance and trying to balance the budget, you would like to have lower-risk patients, and I think that is the reason, very simple.

Mr. LINDER. That is obvious, but who is going to turn them away since the health care plan is predicated precisely on absolute universality? Who is going to turn them away?

Dr. DUNN. Well, I didn't say they would be turned away, I just said they would not be welcomed. This is all part of marketing, providing care, providing a continuity of care, and providing services that are at a level and quality that have been received before.

Secondly, for many of the services needed, the private sector is really not well prepared to provide them. A very good example of that is spinal cord injury and limb removal rehabilitation. That is a service well developed in the VA, an excellent service, and it is simply very rarely found in the private sector.

Mr. LINDER. Dr. Garthwaite, you discussed the basic entitlement, basic benefit package—who is going to decide who is entitled to what?

Dr. GARTHWAITE. I think basically the providers of the funds. I would think Congress has a significant role in that.

Mr. LINDER. And when you have Congress making decisions about entitlements, when have you ever seen a government pro-

gram run by government or Congress that provided the kind of flexibility you desired to have?

Dr. GARTHWAITE. I don't know that I am a good witness to understand all the programs the Government runs.

Mr. LINDER. Just name one.

Dr. GARTHWAITE. Right.

Mr. LINDER. Just name one.

The point I am making is that when you are looking to public monies and Congressional action for determination of who is entitled to what, you are going to naturally have all of these regulations, and I don't see any possible hope of turning over to individual chiefs of staff the decision on who to treat, and how much treatment, and when to buy, and what the budget could be, because I suspect that you would like to include all dependents in your area so the whole family could be treated.

Dr. GARTHWAITE. I am not suggesting that we be allowed to determine who is entitled. By flexibility, I mean the ability to be able to provide those services more easily, for example, the ability to provide services with contracts or to have sharing agreements where it makes the most sense.

I will give you an example. We have had a sharing agreement in lithotripsy and have the first lithotriptor in the State of Wisconsin at the VA hospital. A private patient goes into an affiliated hospital, gets in an ambulance, comes over and gets his lithotripsy at our hospital, and then goes back. It doesn't interfere at all with the veteran. As a matter of fact, it makes it better for the veteran because we couldn't have afforded the equipment without the sharing arrangement. The veteran gets his care in the VA, he is the one who is not inconvenienced as compared to the private sector patient, and everybody wins. The nurses that help take care of the patient are hired under the sharing agreement, paid for proportionally by the patients who use the equipment.

So it is a need for the flexibility to do what we think is right. We don't suggest that we should determine who is eligible. I think we just suggest that there may be creative ways to deliver what all of us want to deliver, which is efficient, good care.

Mr. LINDER. I have one more question. What percentage of the patients in your facility are either addicted to alcohol or drugs or are HIV positive?

Dr. GARTHWAITE. I am sure I know the exact percentage. We have a relatively small percentage of HIV because Milwaukee is an area where the disease is not as prevalent as compared to some other cities in the United States, so I would say it is a small percentage for HIV.

Alcohol addiction is very prevalent, and I don't know the exact addiction number, but those affected by the drug is probably 30 or 40 percent.

Mr. LINDER. Thank you.

Mr. ROWLAND. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I am sorry I wasn't here a few minutes earlier to welcome Dr. Dunn, who comes from my area—in fact, Dean of the medical school that my son recently completed his residency in.

Welcome, sir.

Dr. DUNN. Thank you.

Mr. BILIRAKIS. Dr. Garthwaite, you have been asked a number of questions, and with all due respect, how long have you been with the VA?

Dr. GARTHWAITE. I have been in the VA about 19 years, chief of staff for 6 years.

Mr. BILIRAKIS. Nineteen years. You must know that the veterans' service organizations and veterans around the country feel very, very strongly about veterans' health care being kept separate and independent and not part of the overall system, the mainstream concept.

Dr. GARTHWAITE. Correct.

Mr. BILIRAKIS. Do you agree with that?

Dr. GARTHWAITE. I certainly believe in providing the best care to veterans and allowing us to do that in the best way possible. But also, I think that if we are going to provide those services, that we have to at least consider how we maintain that ability, and I think to provide high-quality care in all these subspecialties of medicines and to have the critical mass to do that and do it well requires enough patients to keep that expertise flowing and working well.

I also think that it may be to their advantage to be able to have their family treated at the same place as they are, especially in rural areas where there may not be other outstanding private care or facilities. I am not in any way suggesting—and I hope no one gets that idea—that we want to exclude veterans. I try to treat as many veterans as possible.

Mr. BILIRAKIS. Well, no, I don't think anybody is getting the idea you want to exclude veterans, but there is the concern, not as a result of anything you have said, but there is the concern that by blending veterans health care with health care around the country, that you are really getting rid of the independence.

You were asked a number of questions by the gentleman from Georgia—and again I say this respectfully—you had a hard time answering some of them. I suggest to you, sir, you are going to have to learn those answers if you are really going to try to be protective of veterans' health care.

The question was asked about who is entitled, and that sort of thing. Right at this point in time, it is this Committee and the Congress of the United States and you good gentlemen who make that decision. Under a health care plan that establishes another two levels of bureaucracy, that basically will define and spell out health care and what will be available and how much will be available for whom and what the eligibility will be, it takes that away from VA.

I am not even sure that we should have or could even have a health committee, or a health subcommittee, in this Congress. Certainly, as I see it, the Health Security Act would take away Congressional oversight and responsibility.

You spoke about the uniqueness of veterans health care—I guess I am preaching more than asking questions here—we have been trying to get the spinal cord injury unit in Tampa, which is a fantastic facility, enlarged for a long time and, I might add, it has been getting on the VA budget lists continuously and then changes take place.

But, the fact of the matter is, it won't be the specialists and the experts such as yourselves that will determine the level of spinal cord injury beds that might be required, it would be this other bureaucracy, the National Board. Isn't that true? Don't you see it that way?

Dr. GARTHWAITE. That often happens, yes.

Mr. BILIRAKIS. I mean you made a statement, "We believe that the proposed role for the VA health care system is reasonable and offers us an exciting opportunity. We believe VA can perform well under these plans based on our experience in providing comprehensive care within a global budget." I do agree from that global budget standpoint this is basically what you have had to live with.

But then you go on and give us five very salient exceptions or concerns that you have.

So I would suggest, sir, that, as I have told the veterans' organizations time and time again, we all must remain diligent and vigilant and whatever other adjectives really apply to make sure that what we have now, which is far from perfect but pretty darn good, is not destroyed as a result of being cranked into the overall system.

Thank you.

Mr. ROWLAND. The gentleman's time has expired.

Mr. Bishop.

Mr. BISHOP. Thank very much, Mr. Chairman. I have got just a couple of questions.

Obviously, one of the key elements of health care reform is access, universal access. With regard to veterans, veterans are spread across the country and of course in the various States there are numbers of veterans who are not geographically near VA medical centers.

I noticed, in Dr. Dunn's testimony, you did reference some cooperation and some cooperative relationships with DOD. I was wondering if you had given any thought to that, if you thought that that would really be an effective way of providing access to many veterans who are challenged because of the distances they live from VA facilities in terms of their primary and preventive care.

Obviously, chronic and acute situations would require referral to some more specialized institution, but for primary and preventive care, routine care for veterans, there are a number of base hospitals and military hospitals in areas where there are no VA hospitals.

Would you recommend perhaps combining of resources between VA and DOD for the joint use of military hospitals, perhaps developing VA wings or VA clinics attached to the military hospitals existing? Could you both respond to that?

Dr. DUNN. I welcome that question, because I think what you are suggesting is right on target.

With concern to whether the VA system could still continue as a single isolated system, I think it is very doubtful that any of us can. I think we all are going to have to work together and to share. We also need to watch out that we don't lose caring for those that need it.

If I can use an example in my own area, we have the Tampa VA; 38 miles away is the Bay Pines VA. The Tampa VA has an out-

patient clinic at Orlando, at Port Richey, then at Tampa, Bay Pines, and all the way down to Fort Myers. In that crescent, we see well over a half-million outpatients a year, and the number is growing and growing.

Now, what we all must do is provide more preventive care, more primary care, more early interventions so we use the hospitals only when they are needed.

The VA system has decided there are so many veterans now in Central Florida, a new hospital must be established. I am very pleased it appears that it is now going forward, that a decommissioned Navy air base hospital in Orlando is going to be transferred to the VA so that the VA does not have to build one. Now this is the kind of rational planning that I would like to see more of.

The Tampa VA has an exchange arrangement with MacDill Air Force Base so that they trade services. The two VAs trade services as well, and this is the way we will all save. We also must get more VA and private sharing and trading.

Dr. GARTHWAITE. I don't really have a lot of add. I think we have some good examples of where this already occurs, and I think we should be open to other places where it makes sense. I agree.

Mr. BISHOP. Thank you.

With regard to the cooperative efforts with some of the medical schools, I also notice that you reference, I suppose on the provider end, having a cooperative relationship with the medical schools, I guess to provide an additional source of medical providers, residents, interns, and the like. I assume that is the reference that you would make.

Dr. DUNN. Yes, plus physicians. Our faculty for VA staff and VA staff for our faculty as well, so it is a seamless mix of people.

Mr. BISHOP. Do you think—and I am just asking—that medical school professors would really be interested in doing the routine kind of work that a primary care physician would do?

Dr. DUNN. I hope so, because they do it now.

Mr. BISHOP. Thank you.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you.

Dr. Kreidler.

Mr. KREIDLER. Dean Dunn, I would like to go to the same issue here dealing with the residency training programs that the VA has provided historically and the change in mission that is taking place here with the emphasis on primary care.

I think most of us recognize that we are probably 180 degrees out of whack relative to primary care in our residency training programs in this country. I am curious to see if you see the medical schools prepared, to step up to this in their relationship with VA hospitals, to reorient perhaps, to see twice as many primary care residency training activities or residencies in those programs as specialty.

Dr. DUNN. We don't have the answers, but we are prepared to work with everyone on this. It is a serious problem; we recognize it. I can give you once again my local example.

Florida has three allopathic medical schools and one osteopathic medical school. My colleague deans from the other three schools and I have been meeting together over the past 6 months. We have

come up with a formal, conjoint proposal on developing generalist physicians, and we have given that to the governor. As you know, Florida has one of the more advanced health reform plans going into effect. It calls for exactly this: that we will, in fact, reduce the number of subspecialty residency positions, and we will increase the number of generalist positions. This includes our VA affiliates, the Miami VA, the Gainesville VA, Bay Pines, and Tampa. It also includes Tampa General Hospital, the Shands Hospital, the University of Florida, and Jackson Memorial Hospital in Miami. We are approaching this, and we want to keep all of these participants together.

We believe if the VA, for example, is separated from us in the reallocation of residency slots, we will all lose.

Mr. KREIDLER. Good point.

Dr. Garthwaite, I would turn to you since we talked about Florida here and it has a rather advanced health care reform program being initiated. I think that the State of Washington probably is a little bit ahead on that because it includes an employer mandate which Florida's did not.

Local VA centers are obviously very concerned that they be allowed to function as accountable health care plans, and I believe you pointed that out in your testimony. Do you think they are ready to function in that capacity? What is going to allow them to function as an accountable certified health care plan?

Dr. GARTHWAITE. I think we already provide comprehensive care to many patients. I don't see that that is different. I think this is a different funding mechanism, but I think for many of our patients we provide comprehensive care at this point.

Mr. KREIDLER. I certainly think so, particularly to the male veterans, but I am thinking now that if you have to see a major transition here to women and children, it appears that it is going to be a significant adjustment for most VA centers that I am familiar with.

Dr. GARTHWAITE. I think so. I think we are making great progress in our women's veterans programs, but I think there are many institutions out there which don't provide every service to all their patients. There are very few hospitals who now keep a pediatrics ward going, because if a child is sick enough to be in the hospital, they deserve or they need to be in a children's hospital that specializes in the care of children.

So I would assume most health care plans that include hospitals other than a children's hospital will have to forge a relationship with the children's hospital in that area. I imagine that VA's may also have to do similar sorts of things for women's health care where it makes the most sense, where we don't have the volume to have our own services.

Mr. KREIDLER. Certainly it goes well beyond hospital services, though. It is the outpatient services that play such a key role, too.

Dr. GARTHWAITE. I think most of those are easier to provide. Most of those don't take enormous programs or specialized equipment in comparison to the inpatient.

I would think we could provide a certified gynecologist, for instance, in an outpatient setting where we have the volume without

much difficulty, whereas having an OB suite or an inpatient surgery might be difficult.

Mr. KREIDLER. Dean Dunn?

Dr. DUNN. I just wanted to comment. I think this is one of the compelling reasons we are suggesting forming alliances with VA medical centers and the academic medical centers' other affiliates, because then you bring all the services together and you reconcile them in a cost-effective and easy access mode.

Mr. KREIDLER. Well, we are certainly seeing that across the country right now.

Dr. DUNN. Yes.

Mr. KREIDLER. Certainly in the State of Washington because we are under the gun to proceed a little quicker.

Dr. DUNN. Yes.

Mr. ROWLAND. The gentleman's time has expired. We will come back for a second round of questioning. We have to limit it to 5 minutes, so we will come back.

Mr. Buyer.

Mr. BUYER. Mr. Chairman, it is "Boo-yer."

Mr. ROWLAND. I am very sorry.

Mr. BUYER. That is quite all right.

Mr. ROWLAND. Some people call me "Rou-land," so I understand.

Mr. BUYER. Oh.

I have to agree. I just read your statement, Mr. Chairman. I agree with part of what you said in your statement, and when you underlined the word "free," it did catch my attention. I am in agreement with that.

I missed your testimony, gentlemen, and I am going to review it, especially yours, Dr. Dunn, when you made suggestions that the VA should provide care to dependents. I want to become very open to this process, even those areas in which I disagree with your testimony. So I want to take a look at what your basis for that view is, because that is an area in which I disagree. But I am more than open, and I will take a look at it. Thank you.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Buyer.

I have a couple of questions I want to ask.

Dr. Dunn, you suggest in your testimony that an environment of competition could endanger the VA academic affiliations. What is the worst case scenario that you see in that?

Dr. DUNN. If the VA is kept as an isolated system but the patients in the future have even greater choice than they do now, and go elsewhere, the worst case scenario is that the critical mass of patients for a given service in a VA hospital becomes too small to be cost-effective and provide the care.

I think one must guard against this very carefully, because there are optimal numbers of patients for given types of services in order to maintain those services. I think that is where for all parties in a given plan—as for example what we are proposing, the academic medical center, the non-VA partner, the VA partner—success and failure is for the entire group, not for just one.

Mr. ROWLAND. How about in rural settings where there is not an affiliation with a teaching institution? How do you see the hospitals

faring in those areas insofar as their relationship with hospitals in the community?

Dr. DUNN. Many of my colleagues over the country are developing rural health initiatives, and I think this should include veteran patients as well. If we have these cooperative alliances, it would allow that to happen.

The problem of health care in rural areas is not limited to the veteran by any means. Medical schools are all very interested in this. We realize there is an opportunity here for our students to provide care while they are in training.

Mr. ROWLAND. Dr. Garthwaite, what vision do you have regarding the future of VA affiliation with medical schools under health plan models which would encourage institutions to compete with one another?

Dr. GARTHWAITE. I am concerned that there will be some additional tensions between VA medical centers and competing hospitals, but I also think there are compelling forces which drive the medical schools and the VA together. One of those forces is the VA's support of residency and fellowship training positions and the infrastructure where it allows that to happen. We support a lot of graduate medical education, and that is not easily duplicated in another system.

I think that the patient load is vital to the success of those educational opportunities and that the medical schools will see that.

I think the support of research is also important, which helps both of us meet our missions. But, in addition, I think that, as Dr. Dunn has suggested, that the forging of sharing agreements and contracts with academic medical centers could work to improve our efficiency and their efficiency and both of our competitive edges, similar to what I described with the lithotripsy example.

Mr. ROWLAND. Yesterday the VA responded to a question from the PVA regarding nonveterans receiving care in a VA facility under a quid pro quo sharing arrangement. The VA stated that although current sharing agreements would remain in effect, "the Secretary has stated that he would endorse additional agreements considered for ancillary services such as x ray and lab." This is somewhat limited, I think, from what you have been talking about. How do you review this, either of you?

Dr. GARTHWAITE. I think we might be confusing sharing agreements with denying a space for a veteran. If we have funding for additional veterans to receive care in VA hospitals, I think we can care for them. Sharing agreements just say we need to share certain highly expensive things or other services for which they pay us money which we can keep and hire the staff to provide those, and it just allows us to set up programs efficiently and well. It does not, in my opinion, deny anybody anything. It helps to provide a service that we otherwise couldn't provide. I think there can be some confusion regarding a war-veteran occupying a bed in a VA hospital. The cost of care is being paid for by another source, and that extra funding brings not only the patient and funds but allows us to offer that service at the VA hospital and to the veteran. I think that is an advantage, not a disadvantage.

It appears when you first look at it that a nonveteran is taking the place of a veteran, but I don't think if you really look at it in depth, that that is actually what is occurring.

Dr. DUNN. May I comment on that?

Mr. ROWLAND. Yes, please.

Dr. DUNN. I think the spinal cord injury program is a very good example of this. Mr. Bilirakis is very familiar with the one at Tampa and is also responsible for its success. It is a tremendous resource to the community. It should be first for the veteran, but once the resource is there, it cannot be duplicated readily by the community where the need is not so great and the cost is totally out of sight to have such a large resource with little utilization. Whereas the VA has one, through sharing it would become then a community resource, but the veteran is still given priority admission.

The Tampa VA spinal cord injury program is an excellent example of continuum of care in that the patients have home care, long-term care, integrated care, and they have even gone to the family practice mode of having a fellowship for fourth-year family practice residents to work in the spinal cord injury unit so they can learn the continuity of care in a way that is reasonable, not so high cost. One learns not to have the patient go from this subspecialist to that and that, and I think it is a good role model for us all to learn from.

Mr. ROWLAND. Are there Members who desire to have additional questions now?

Mr. BILIRAKIS. One quick one, if I may, Mr. Chairman.

Mr. ROWLAND. Mr. Bilirakis.

Mr. BILIRAKIS. Both of you gentlemen referred to States drafting their own health care plans. Mr. Kreidler says that Washington's plan is ahead of Florida's plan. That is beside the point. We won't compete in that regard.

But, Dr. Dunn, you mentioned, of course, that Florida is far along in its reform, and it is. In your opinion—and I am always concerned with this role of VA; I think Dr. Garthwaite knows where I am coming from here—I am always concerned about it. Has a role, in your opinion, been adequately defined for the VA as a part of the overall State Florida plan?

Dr. DUNN. Absolutely not. I do no believe so, sir, and I think that is one of the concerns that the four medical schools in Florida have, that we do not see an appropriate role for the academic medical centers, first of all, and, secondly, our very important partners of the VA are not there either. So we are working together to try to find this role, and that is one of the reasons we welcome the opportunity to come here. We are well aware of where the Federal rules are made.

Mr. BILIRAKIS. Whatever is decided down there among you all and the State of Florida would have to be coordinated with us here so that there aren't any conflicts insofar as the regulations and the legislative role.

Dr. DUNN. No question about it.

Mr. BILIRAKIS. There are so many complications as a result of this meshing together, and we have all got to be aware of that, and that was the point I was trying to make, Dr. Garthwaite. Certainly

I wasn't trying to be difficult, but it is just that there is so much more to all this.

Dr. DUNN. If I can emphasize one point, sir, from my testimony on behalf of the Association, it is that the health care system in general and the involvement of the VA and the academic medical centers in particular is so complex and so fragile that it would be a grave error if any of us tried to deal with one problem in isolation and ignored the others, because they are all interlocked.

Mr. BILIRAKIS. Thank you, sir.

Thank you, Mr. Chairman.

Mr. ROWLAND. Dr. Kreidler.

Mr. KREIDLER. Following in that same vein, I certainly will find it interesting. I believe the VA is planning to come with legislation that would grant VA centers, in States where they are proceeding at a more rapid rate, the authority to participate in health care reform so that the Floridas and the Washington States can be responsive, so that they don't leave the VA centers out in the cold and then try to come back and reinvent the wheel.

That leads me into the issue that, as that authority is granted, whether it is because of the national plan or because of entities with State plans, local autonomy to negotiate with health alliances that have the ability to adapt to marketplaces, as you, Dr. Garthwaite mentioned in your testimony, how do you see that working?

Do you see the VA directors having the authority to do this, or do you see this operating with a board that may be appointed to oversee the operation of VA centers that become certified health plans?

Dr. GARTHWAITE. We don't have a lot of experience in this, but I think that it has to be at a local level. Whether that is a director or one step up from that or whether it would be helpful to have a board with a group of people with varying expertise remains to be determined.

I have a sense that a board would be helpful if we could engage people who have had some private experience in the academic medical centers, the medical schools and others to be part of that.

Mr. KREIDLER. I personally think that works well. I worked for Group Help Cooperative Puget Sound for 20 years. It is a consumer cooperative that operates with a consumer board that is not salaried or paid, and it is elected from people who belong to the health care plan.

But I think something that incorporates that, such as the medical schools, and certainly the veterans' organizations, any number of consumers, plus providers that make up and participate with the plan, would be invaluable to make sure that it is adjusting its direction.

I think that may be part of what we should be contemplating at some point, granting authority to VA medical centers to participate as certified health care plans, that authority in order to make sure that the centers have flexibility to adjust.

Thank you, Mr. Chairman.

Mr. ROWLAND. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman.

Now that I have reviewed both of your testimonies in regard to care to dependents, now I am going to ask you some questions on it, and if I am being redundant, please bear with me if any of the questions were asked before I arrived.

When you have a VA and you are operating under a global budget, and especially at a time when we are going to be restricted in our dollars anyway, and we are going to bring in dependents, it begins to take away from the care to actual veterans for what the purpose was set out to do. So when you add more into the pool and have that dilution, you begin to take away some of the care for the veterans.

When you mention in here, Dr. Garthwaite, "Our second concern is, we would need to be able to provide care for veterans' dependents, since many veterans will want to enroll in the family plan," is that your own personal view, or have you done any studies to show that that is what veterans are going to want to do—is enroll their families into the VA?

Dr. GARTHWAITE. I think it is more of a gut instinct. I think to suggest that bringing in dependents to be expected to be cared for out of the appropriation for veterans is not what I am suggesting. If they don't come in with the additional resources to provide their care without displacing veterans, I am against it.

So I am not suggesting in any way that nonveterans would come in and displace veterans who are entitled; that is absolutely not the case. But if you are sitting there looking at a group of accountable health plans, and you have single or family options, and you look down the list at what is provided, and the VA provides only single option, and you have a family, and you would like to both be treated by the same physician, for instance, because you have trust and developed a relationship, then I think to have that option would be important.

Mr. BUYER. Okay, but I want to make it clear that this is your gut feeling and your personal testimony, not based upon any studies you have done out there among veterans.

Dr. GARTHWAITE. Correct.

Mr. BUYER. All right, because there are a lot of veterans out there that see the veterans hospitals as very sacred; it really is. Even my own veterans hospital I have in Marion, Indiana, and the VA clinic, it is almost pretty sacred ground when you go in there and you see a lot of the veterans.

So I want to recognize that, and that is why I mentioned in the testimony of Dr. Rowland about the independence of VA, which I am in total agreement with. But I am willing to listen and participate in the openness of this process. I am keenly aware, though, of many that would like to cite the VA and say, "Well, look at how the VA can provide some quality care under global budgeting; therefore, we can take the entire health care system of America and we can stick it under a global budget and we can provide the same quality of services that you can get now in the private sector."

So I am very careful to watch those that try to take that and say that is why we need to have a national health care system of America. They like to hide it under national health care reform. But, believe me, I am keenly aware of what I see happening.

Thank you, Mr. Chairman.

Mr. KREIDLER (presiding). Thank you.

Any further questions?

We very much appreciate your testimony, gentlemen.

Dr. DUNN. Thank you, Mr. Chairman.

Dr. GARTHWAITE. Thank you.

Mr. KREIDLER. I would like to invite the next panel to come forward, please.

Mr. ROWLAND (presiding). Our next panel is Mr. Frank Buxton, who is with the American Legion; Mr. Dennis Cullinan of VFW; David Gorman with the DAV; Mr. Michael Brinck with AMVETS; and Mr. Gordon Mansfield with PVA.

Gentlemen, thank you for being here this morning. We would ask that you limit your oral testimony to 5 minutes, and your entire testimony will be submitted for the record.

Mr. Buxton.

STATEMENTS OF FRANK BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; MICHAEL F. BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND GORDON MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF FRANK BUXTON

Mr. BUXTON. Good morning, Mr. Chairman, and subcommittee members. The American Legion appreciates this opportunity to participate in this discussion of the impact of national health care reform on the VA.

At this time, we would like to talk to several points which we feel are significant to the success of VA under the administration's Health Security Act.

First of all, Mr. Chairman, I would like to emphasize that the Legion has never suggested that the VA operate in total isolation from the private sector, but in collaboration as a system which has veterans as their primary constituency.

Last year, the American Legion published a Proposal to Improve Veterans' Health Care, and we are pleased that the administration's Health Security Act embraces about 85 percent of our recommendations. We understand that the draft bill that we have reviewed may change in many ways before it is made into law. We do have some concerns, however, for the future of VA health care under reform as we read of it today.

We have repeatedly indicated that VA cannot successfully compete in the health care reform arena while still shackled by old restrictions on who may be treated in the VA health care system and how that treatment gets paid for.

If there is a clear intent to place the VA in the competitive environment, the field on which that competition takes place must be level. To engineer the removal of any elements of the administration's overall goals of the Health Security Act, such as security,

choice, quality, participation, and the lowering of cost by restricting VA's ability to obtain equitable reimbursement for the costs of care that it renders, certainly places that Department at a distinct disadvantage.

We are referring to the prospect of requiring certain reimbursed dollars to be returned to the General Treasury of the United States much as it is today. Time and time again, we have attempted to aid the understanding that there are two distinct groups of veterans which the VA will treat, those that are service-connected and those that are not. Similarly, there should be two funding mechanisms, appropriated dollars for the care of service-connected and poor veterans, and reimbursed dollars for the care of other persons who come to the VA for care. Simple procedures can be put in place to assure that these funding streams do not mix if that is necessary.

Opposition to Medicare dollars flowing to the VA for the care of Medicare eligible veterans, for instance, assures that the playing field will not be level. It must be understood that Medicare reimbursement to the VA has nothing to do with making money and has everything to do with equitable remuneration for services rendered.

To take reimbursed dollars away from the VA after services are rendered can only force the VA to reduce access and quality, not to mention the ability to remain a secure health care environment for those who come to the VA. Such inability to render a high quality continuum of care places the veteran who uses the VA at a greater risk for securing health care, and no one in the country should be subjected to that under national health care reform.

Mr. Chairman, many States will initiate their own health care reform plans prior to the enactment of the Health Security Act. This proactivity should be commended. However, the eligibility guidelines which are presently in place would not allow VA to compete for veteran patients should the State plans be enacted before the passage of the Health Security Act. Some provisions must be made to allow VAMC's in such States to join the competition without the restraints of convoluted eligibility laws which exist today.

Mr. Chairman, in addition to the outside forces which may determine VA's fate, certain changes must occur within the system. First, the VA must have access to the seed money available for transition to a new delivery environment. Older facilities must be funded to bring their physical plant and staffing to acceptable levels.

Another area of concern with VA's entry into the world of competition is the rapidity with which the VA can develop the primary care system of health care delivery. They must be given every opportunity to accomplish this change. Some areas have already developed primary care teams, and the remainder must be empowered to move forward now.

Mr. Chairman, ambulatory care provision is a major component of efficient and cost-effective care, and the VA must move to improve this arena as well.

Another concern of the Legion involves eligible veterans' dependents. Veterans could be discouraged from enrolling in a VA health care plan because their dependents may not be eligible to enroll in

the same plan. The Health Security Act allows the Secretary of Veterans Affairs to open the system at certain locations to dependents at his or her discretion. It is suggested that the VA consider opening the VA health care plans to dependents with the assurance that every eligible veteran enrollee will have had the opportunity to afford themselves of the benefits package offered by such VA. Such a plan would have to undergo serious examination as to the impact on veterans prior to such a move. Some services could be contracted out if not available at the VAMC.

The American Legion believes that if the proverbial playing field maintains a level stance, the VA changes should provide quality, efficient, accessible health care without deterrent. They can become a competitive player in the health care arena.

We look forward to sharing our concerns and opinions with you and others as we carefully shepherd this historic Act through the legislative process. You can be assured that we will not be timid in voicing our advocacy for America's veterans.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Buxton appears at p. 112.]

Mr. ROWLAND. Thank you.

Mr. Cullinan.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the entire membership of the Veterans of Foreign Wars, I wish to thank you for inviting us to participate in today's most important hearing.

Through the years, the VA health care system has been of profound importance to veterans throughout the Nation, and in carrying out this Nation's obligation to care for her military veterans in their time of need. The VA health care system has also proven to be of great service to nonveterans as well. VA contributions in the areas of medical research and education have be instrumental in making overall American health care and science the best in the world.

As we are all aware, President Clinton has revisited and revamped his national health care plan, and as we understand, it is being refined even as we speak.

While the VFW certainly has no objection to reworking national health care with respect to financing and reducing some of the bureaucratic burden and placing new limits on taxpayer subsidies, we are adamant that the administration hold fast with respect to its promise to assure that the VA health care system remains as an autonomous health care provider for America's veterans.

VA must never become just another health care provider. It has a special trust and obligation to a very special segment of the population. Competition and all that it entails is all good and well, but VA should never be viewed as just another HMO.

Mr. Chairman, in addition to the VFW concerns and points delineated in our written statement, I would now like to make a few other observations and concerns of the VFW here today.

The VFW agrees that medical school alliances and affiliations should be maintained, and in fact in the face of national health care reform this kind of networking should be perhaps even more

aggressively pursued. But we maintain that this must not lead to the mainstreaming of VA health care. We would point out that medical schools are populated by brilliant, aggressive individuals whose concerns transcend the everyday concerns of primary health care. But primary health care must remain VA's main business. We certainly support alliances, sharing arrangements as they now exist, but this should not supplant VA's primary mission.

Another VFW point is that, with respect to national health care's treatment of the States, allowing States to have certain reign over the type of care that is provided. As its stands right now, the States would be allowed to mandate that anyone, everyone, including veterans over age 65 would be turned over to medicare. Now this would be completely contrary to the VFW's view of what national health care should mean and what VA health care should mean for veterans, and we think this is something that has to be looked at and, in fact, the problem eliminated.

We are also adamant that service-connected veterans and the so-called Category A veterans not have to pay for health care which is in excess of the so-called standard benefit package as provided under national health care.

Our interpretation of national health care at this point in time is that, if VA is providing more to a service-connected or so-called Category A veteran, then he or she may have to pay for a portion of that care either directly or through his work or insurer. We totally disagree with that.

We are also distressed that the health care premiums paid by employers and by veterans themselves would also be applied to service-connected care. Again, as we understand it, under national health care the employer is expected to pay 80 percent of the cost of a veteran or nonveteran's insurance and the individual, the patient, so to speak, pays the other 20 percent. We would point out that a portion of this then in the case of a service-connected veteran would be applied toward service-connected care, and that is indeed very problematic.

We would also emphasize that the VA must receive sufficient funding and staff to allow it to fully provide for an expanded universe of patients and, in fact, for it to march into the modern era of medical care. This is something you have heard a number of times already today, but it is so essential that VA be allowed to collect resources and to retain these resources and then apply them towards modernizing its facilities and allowing it to care for the veteran population and to entice the veteran population to choose it as its health care provider of choice.

Finally, we also understand that VA must treat its patients very well, and this has to do with the fact of VA and the image of VA. There are many veterans who, given the choice—and, again, this is a choice that has been brought out today—given the choice, would not elect VA if they had their druthers. The reason for this, there is in fact in certain VA facilities a kind of bureaucratic mind set which mitigates against someone choosing it of their own will.

I would summarize it this way. Oftentimes a veteran, or anyone for that matter, may not be able to very well gauge the type of health care they are receiving, but they know how they are treated at the door, and VA really has to come up to speed in this regard.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cullinan, with attachment, appears at p. 126.]

Mr. ROWLAND. Thank you.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you. Good morning, Mr. Chairman.

I think you said in your opening statement, that there have been a lot of hearings held in the past by this committee and by this subcommittee and others with an interest in health care, and I agree with that, and a lot of the things that we have said in the past I won't bother to repeat today because I think they set the stage for the concept of what we believe health care reform in terms of what VA should be doing has already been said.

There are three fundamental features that the DAV has always advocated as concerns health care. One is access to care, one is the scope of care that is going to be provided, and the other is the funding mechanisms that are going to provide that care.

Under the scenario laid out in the Health Security Act as concerns and only in the context of the VA—we haven't reviewed nor endorsed the other parts of the health care plan and we don't intend to—but as far as access is concerned, we are supportive of the way veterans are being treated in as much as the veterans that we believe the VA should be mandated to treat, that being the service-connected and the lower-income veterans, will be able to avail themselves of that care.

Additionally, the scope of care or the basic benefits package that the VA is going to be able to provide to those veterans is going to be equal to and in many cases greater than is going to be provided to other citizens of the country, and that, we believe is a continuation of the Federal Government's and the VA's responsibility to take care of veterans. We also agree with that.

The funding mechanism conceptually we agree with, although we have some lack of understanding of exactly how it is going to work concerning appropriated dollars versus nonappropriated dollars, what the nonappropriated dollars—what kind of care they are going to pay for versus what the appropriated dollars are going to pay for.

Our view would be, appropriated dollars by the Congress should continue in their current form, perhaps not their current amount but at least in their current form, to take care of the service-connected and the low-income or the core entitled veteran, and I think, as Mr. Buxton said, funding streams that have been outlined in the plan and certainly have been talked about by all concerned with VA health care should pay for the care of—for the sake of a term—the noncore veteran.

We do need to see, however, further information on that, and we need to understand in the context of this plan how that is going to work a lot better than we do right now.

We are very pleased that the independence of VA is going to be maintained, perhaps not as a totally independent or isolated system, but the independence of a separate VA health care delivery system will be maintained.

Also important, I think, is the fact and the covenant that has been extended by the administration that there will be no diminishment of services to veterans who are now entitled to services under Chapter 17. We view that as certain service-connected veterans who now have entitlement because of their degree of disability or the nature of their disability and can avail themselves of certain kinds of specific benefits won't lose that entitlement when health care reform in some fashion does kick in.

I think Dr. Garthwaite mentioned one extremely key element that we have been concerned with for some time, and that seems to be the culture in which the VA is operating under right now and has been for a long time. We think that culture needs to change. I don't think necessarily it is a question of who provides or dictates what benefits will be provided but rather how they are provided.

Long-term care, that discussion, doesn't necessarily equate to a nursing home care bed, but other kinds of noninstitutional kinds of treatment that are less expensive certainly improves and maintains the veteran's quality of life. The VA does not have the opportunity or the authority in many cases to do that, and they need to have that. They need to have the authority to provide care in a less expensive mode than a hospital bed. They need outpatient capabilities they don't right now have.

They also need to be granted some kind of authority for easy access or a point of entry into the system through outpatient clinics spread across the system, not necessarily located within VA medical centers.

I would make, perhaps in closing, because I think this is an opportunity for some frank discussion and some questions, one question regarding dependents of veterans. The DAV has not and will not advocate that an open door blanket policy of nonveterans should flow into the VA system. However, we do think the VA runs a great risk in making a blanket statement that dependents of veterans will not come into the system, and a lot of those reasons have been discussed already.

It is interesting that at the monthly VSO and CMD meeting that was held yesterday there was some discussion of the CHAMPVA program, of which I think we all know that dependents of 100 percent service-connected veterans are offered the option to have their treatment received within the VA if they so choose. Of those that have, the VA was able—and it was a small number, but nevertheless the VA was able to return to those few medical centers providing that care to a relatively small number of dependents about one and a half million dollars that the VA in those centers, wherever, were able to plow right back into programs that benefit veterans.

So I think it is a situation that we need to discuss. I think we need to have an open mind, and I think we need to view what happens if we don't at least consider treating the dependents of certain veterans within the VA.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gorman appears at p. 134.]

Mr. ROWLAND. Thank you.

There is a vote on. I believe we will have time for Mr. Brink's testimony, and then we will go vote.

STATEMENT OF MICHAEL F. BRINCK

Mr. BRINCK. I will read fast. Thank you Mr. Chairman. AMVETS is pleased to be here this morning.

There is one overriding principle we should keep in mind as we proceed together towards reform. VA medical care cannot go on organized, managed, and delivered in its current form. If the system is left unchanged, it will surely die. VA medical care will go from a highly diverse, full spectrum health care provider, a respected research organization, and a national emergency backup, to an old soldier's home at best. We will have squandered a national asset.

The veterans' organizations here today have been testifying for years about the need to do business differently. It is encouraging to see the President's plan incorporates many of the ideas we have espoused. Many States are ready to start reform soon, and we will support implementing pilot programs to allow VA to test new delivery models as well as eligibility reform.

Pilot programs will let VA learn how to do it right, and, more importantly, how not to do it. Will there be mistakes? Most likely. But the bigger mistake would be to prevent VA participation in local reform, thereby losing any chance of retaining the loyalty of veterans in the area as well as garnering additional potential market share.

Pilot programs will not be painless. Many VA medical centers serve populations from several States, and until all surrounding States have put health alliances and funding mechanisms in place, it appears that transitional funding from the Congress will be an issue.

Will veterans from surrounding jurisdictions also be treated under the new rules? Will there be two levels of care? Will the Congress provide the funds to make a smooth transition?

This brings about our second concern, appropriated funding. AMVETS recognizes that VA will have to compete for nonappropriated funding streams, but they must not be punished for being successful. We are already hearing rumors that OMB intends to reduce significantly the appropriation for the VA medical system. The Federal Government must not abandon its financial and moral responsibility for those most deserving of our veterans, the service-connected and those who are medically indigent. We call on Congress to devise a funding formula based on a core veteran capitation that will ensure VA managers of a dependable funding base.

Third, the issue of treating nonveterans in VA facilities must be addressed. It has long been our position that we would be willing to discuss such treatment only when all veterans have been accommodated within the VA system. It now appears that VA has moved to provide access to all veterans in one form or another, and now is the time to begin the dialogue on the extent to which the VA system and veterans will benefit from treating nonveterans.

It is relatively easy to extend the privilege to the dependents of veterans, and it makes especially good marketing sense to bring in the spouses of veterans because they often make the choice on where the family goes for its health care.

Treating spouses will also help attract sufficient women veterans to justify in-house gynecological services. Active duty service members and their dependents are also members of the veteran's ex-

tended family, and the progression from the DOD medical system to the VA is a natural one that captures a client base accustomed to the style of medicine practiced by the VA.

What we really need now is to see the final part of the strategic VA plan, the programmatic information that will show how VA intends to adapt to the new realities created by the Health Security Act.

The lesson here of the rural health care fiasco is that we simply want to be part of the planning process as new programs are designed and implemented, so let us help. Don't keep us in the dark about these plans. Let the working relationship between VA and those it exists to serve act as a model of how Government serves the people, not how Government rules the people.

There are surely some provisions that will be difficult for the veterans' organizations and Members of Congress. But if the plan is presented as a coherent whole where we can see that a loss in one area, maybe geographic or clinical, means significant gains for veterans in another, we can be expected to react in a manner that benefits not only veterans but the Nation as a whole.

But if the plan is presented as just another round of cuts in health care services, we can only react to protect the status quo. AMVETS hopes this does not happen, and we await VA's strategic implementation plan.

Mr. Chairman, our written statement contains comments on specific portions of the bill, and I will end my statement here to await your questions.

[The prepared statement of Mr. Brinck appears at p. 140.]

Mr. ROWLAND. Thank you. I appreciate it. We will go vote and return immediately and hear from Mr. Mansfield.

[Recess.]

Mr. ROWLAND. The subcommittee will come to order.

Mr. Mansfield.

STATEMENT OF GORDON MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, it is a pleasure to be here today to express PVA's views on the impact of the administration's national health reform plan on the provision of health care for veterans.

PVA has supported the President's proposal in concept. However, there are many details of the plan that still need to be clarified for PVA to judge exactly how the VA health care system will operate in the future.

The First Lady and the President have promised that the VA will be given the tools to make itself successful and competitive in tomorrow's new health care system, but the question remains, will there be sufficient resources and flexibility to accomplish that goal, or will the VA only be given the semblance of competitiveness and just enough rope to hang itself?

Many of PVA's concerns were submitted in the form of a series of questions sent to the VA on September 22. We received the VA's response yesterday. A copy of the questions is attached to PVA's testimony. Copies of the questions and answers are provided on the

table behind me. We ask that this document be submitted for the record.

[The document appears at p. 153.]

Mr. MANSFIELD. Let me review several areas of concern governing financing that were left unanswered in the VA's response to PVA's questions.

The administration's proposal would require the employers of service-connected disabled veterans enrolled in a VA accountable health plan to pay 80 percent of the veteran's health premium.

PVA is strongly opposed to this provision. It is a major violation of the traditional responsibility of the Federal Government to cover the cost of caring for the service disabled. The provision shifts this responsibility to the employer. It also in many respects takes the premium out of the veteran's own pocket in the form of a health benefit that is given by the employer to the employee in lieu of actual compensation.

Under the administration's plan, the VA would cease to be funded solely by appropriations. Appropriations would only cover those costs of running the system that were not covered by reimbursements, premiums, deductibles, and copayments. The administration estimates that allowing the VA to retain reimbursements will potentially offset appropriations by up to $17 billion over a three-year period. Those appropriated savings would then be shifted to cover the cost of care for other Americans provided for in the bill.

Appropriated dollars are always going to be in short supply for the VA, and as reimbursements rise, appropriated dollars are going to fall. Supplemental benefits will be the first to go. The VA will be unable to support its supplemental benefits programs and Centers of Excellence programs including spinal cord injury centers. Also, most VA plans would be forced to drop their supplemental benefits.

PVA recommends that the supplemental benefits programs be made a clear part of the benefit package. Supplemental benefits should be listed in the statute in the same way that the basic benefits are itemized under the administration's proposed legislation. The Congress should insist that both appropriations and reimbursements be provided to the VA on a capitated, risk adjusted basis. Only this way can the VA be properly reimbursed for the cost of running its system and maintaining comprehensive benefits.

Mr. Chairman, it is inconceivable that the VA is facing major reforms contained in the administration's plan without one word addressed to improve or even define the system's future long-term care mission. The administration's plan provides certain important long-term care services such as nursing home and home care but not within the context of veterans programs and benefits.

Eligibility reform, the provision of the full continuum of care including long-term care for all eligible veterans, is still one of PVA's main objectives. We hope the Congress can achieve the goal with or without the administration's plan. We would like to endorse two proposals that would move us towards this long-term care objective.

Representative Bob Stump has introduced H.R. 3122, the Veterans Long-Term Care Act of 1993. The bill would clearly define eligibility for long-term care services for certain low-income and seri-

ously disabled core group veterans. It would also establish a long-term care insurance program for higher-income veterans, and it would authorize innovative public/private agreements to establish additional extended care facilities to provide long-term care services to the severely disabled veteran population. We endorse this legislation and urge the members of the subcommittee to give it every consideration.

Second, the administration's proposal contains a major innovative program of long-term care, community-based, and home care services to provide assistive services to severely disabled populations. For many PVA members, the provision of a minimal amount of home care services or supervision means the difference between independence or life in an extended care or nursing home facility. Unfortunately, these services are not widely available at the present time in most States and communities. We ask the members of the subcommittee to give this provision in the President's package your full support.

Mr. Chairman, this concludes my statement, and I will be happy to respond to any questions that I can.

[The prepared statement of Mr. Mansfield, with attachment, appears at p. 146.]

Mr. ROWLAND. Thank you.

PVA has expressed the view that under the health reform, rural hospitals could be expected to play a key role in community health care, meeting more of the health needs of veterans and through some sharing arrangements meeting some of the needs of the community.

I would like for the other VSO's to add to or comment on that, please.

Mr. BUXTON. Mr. Chairman, the American Legion has always supported sharing agreements between the VA and other Federal health care delivery systems and the private sector, and it is unfortunate that the rural health care initiative was presented in the form that it was, because that could have been done on some kind of a sharing basis under existing legislation.

We feel that the more sharing contracts there are with other health care entities, the greater the possibilities of more and better care for veterans. Although we would not ever support a merger of the VA with any other health care system, we certainly would be glad to take a look at sharing arrangements as such.

Mr. CULLINAN. Mr. Chairman, the VFW's view on the rural health care initiative is pretty well known, but even so, we well understand that, as national health care and VA health care evolve, that sharing arrangements will be pursued. In fact, I indicated that much earlier in my statement.

We wouldn't want to see this kind of arrangement, though, grow so seamless, to borrow a word that someone else used earlier today, that VA loses its identity or its in-house capability to provide services. That is the problem with sharing arrangements. Its sounds good, and I suppose in an ideal world and if we were only looking at the provision of health care, it would be terrific to just intermingle all resources, but because of funding and other considerations it doesn't quite work that way.

So if sharing were to lead to a situation where VA wouldn't develop its own capability and would, in fact, forfeit some of its identity as the health care provider for veterans, we would most definitely oppose that.

Mr. GORMAN. Mr. Chairman, I think we define sharing as more or less of a win/win situation. The VA should not enter into it unless there is some benefit that can be derived from that sharing agreement. We will continue to propose such agreements to continue when VA can benefit, and I think Dr. Garthwaite, to borrow from his testimony again, made a clear distinction between sharing of services and sharing of hands-on delivery of health care. It is those services such as lab work and CAT scans and those types of things that the VA in fact possesses in many instances in the rural setting that they can avail themselves of to go out and seek, you know, to keep those open beyond the normal working hours that veterans need and require their services and sometimes turn a profit, if you will, from that.

Another example is prosthetics. The VA is into the business now of computerization of the design and fabrication of prosthetics. There is a golden opportunity that the VA has, that doesn't necessarily exist in the private sector, that they can avail themselves of to produce a benefit that, in turn, is going to somehow infuse dollars and benefits back into the system for veterans.

Mr. BRINCK. Mr. Chairman, AMVETS would like to echo what was said by Mr. Buxton and Mr. Gorman. It is important to remember that the purpose of VA medicine is to serve the veteran, and we would continue to support sharing agreements that are designed to benefit the veteran and, incidentally, benefit those who are not veterans. As long as that focus is maintained, they will continue to have our support.

Mr. ROWLAND. Thank you.

Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Gordon, let me thank you and PVA, first of all, for your endorsement of our long-term health care bill; it is very much appreciated. And I would invite the other members and their respective organizations to take a look at it. Now that NAFTA is out of the way, we are going to gear up right after the first of the year and try to give it a big push, and we would appreciate your support if you think it is desirable.

I want to ask you a question that Mr. Bilirakis asked the first panel, and that is, many States are already gearing up for reform plans of their own, and some of these changes are going to be well in advance of any national health care plan. In your opinion, are the VA medical facilities in those States prepared to adapt to changes in access and financing brought about by this so-called reform?

Mr. MANSFIELD. In regard to that, I should point out that PVA has been involved in a project in-house for 3 years to track these developments, and on November 12 I sent a letter to the Secretary requesting that they pay more attention to this concern and offering PVA's assistance.

There is one point I think I should repeat from the letter. In fact, in our review of the literature and State legislative initiatives, only

two States, Washington and Montana, even mentioned the existence of the VA as a provider. So we are concerned that, as we are moving to the possible phase-in in the national health care area, that the VA is already going to be left behind by those States. I believe there are six states that are actively involved and I believe another seven that we know are moving towards it. Our position is that the VA has got to start right now to get involved in dealing with what happens under these State plans.

Mr. STUMP. Do you see the need for some specific legislation?

Mr. MANSFIELD. I think what we indicated to the Secretary is that they should start moving to figure out what they need to do, and if there is a need for legislation, to get down here pretty quick and talk to you about it. We would obviously support that.

Mr. STUMP. Thank you.

Mr. MANSFIELD. In some cases, you may need the waiver for them to participate in some of the activities that they may go forward in under pilot programs, for example.

Mr. STUMP. We look forward to working with you.

Mr. Gorman, do you believe that the infusion of medicare dollars will realistically contribute to capital improvements and infrastructure changes, or will those reimbursements just simply cover the costs of health care?

Mr. GORMAN. I think it depends, Mr. Stump, how the rate of negotiation turns out. I would guess if it holds true that medicare doesn't actually reimburse the full cost of care provided, then the capital improvements that you mentioned may not come about. However, medicare dollars may sort of buffer the care that is provided to veterans wherein other nonappropriated sources of funding can be used for capital investments and, were it not for the medicare dollars, that might not occur.

Mr. STUMP. Thank you.

Let me ask Mr. Brink: You stated in your testimony that the Federal Government must not abandon its financial and moral responsibility for service-connected and medically indigent veterans. We spent months on a package here in reconciliation that attempted to shift some of that cost over to the insurance companies, and the organizations, your various organizations, objected strenuously, which I can probably concur in.

But how can veterans now support a concept that includes shifting that same Federal responsibility over to employers or ultimately to the veteran?

Mr. BRINCK. I am not sure that we do. When we agreed to the concept of the President's plan for the VA, it didn't necessarily endorse the funding mechanism. I think Mr. Gorman expressed it fairly accurately. There are three points to our continual bombardment of Congress about VA: eligibility, scope of treatment, and how it is funded.

We certainly still have from our membership a great deal of concern—as a matter of fact, it may be the only concern that we have seen so far—about how the VA is going to be funded, and there is a lot of concern about the apparent shifting of the burden to the employers especially because most of our membership happens to be either employed by or are small businessmen, and they see this

not only as a breach of the moral obligation but also devastation to them as businessmen.

Mr. STUMP. I didn't mean to point the finger at you, but you know very well that a lot of the veterans were very upset at this idea that the Government would shirk its responsibility.

Mr. BRINCK. Yes, sir, absolutely.

Mr. STUMP. And I am glad it is out.

Mr. Chairman, I will wait for a second go-round. I have got the yellow light there. Go ahead? Thank you, sir.

Let me ask Mr. Cullinan: How can the VA be truly separate and independent under a national board and all the new policy bureaucracy envisioned in the President's plan?

Mr. CULLINAN. Well, Mr. Stump, that is something that greatly concerns the VFW. As we understand it, this legislative package and concept are being refined or worked on even now, and how exactly this will be accommodated within their legislation, that is unclear to us, and this is a concern which we have expressed in the past.

We are afraid that the funding—and this is one of the problems with the sharing arrangements, with overly increased interaction with the private sector, with the fact that, as you just pointed out, employers and veterans themselves will start to pick up a portion of service-connected care. This does, in fact, threaten the autonomy of the VA health care system, and clear distinctions must be maintained.

Mr. STUMP. If in a given region the VA shows some signs of not being able to be competitive, who is going to decide whether you need an infusion of dollars or whether to just fold up and shut the place down?

Mr. CULLINAN. In our view, what should decide it is the need of the resident veterans. Now that is something where, again, we maintain that VA must never be considered to be just another HMO or health care provider. It has that special mission to the veteran population, and if there is a portion of the country that needs to be maintained exclusively through appropriated dollars, then so be it, because this Nation still has an obligation, moral and statutory, to its veterans.

Mr. STUMP. Thank you.

I have one more, Mr. Chairman, if I may.

Frank, do you believe, in your opinion, that the VA can survive in a totally unfamiliar competitive environment with extremely efficient private sector providers?

Mr. BUXTON. We realize that the VA is learning more and more day by day about medical care cost recovery. There are some real basic changes that have to happen in the VA. They have to do a lot of work on the delivery of ambulatory care, they need to move to a primary care type of delivery system, and I think they can over time pick up on that. But, I think they need to, for the lack of a better term, be turned loose now with some seed money to see how they can compete, and if they don't, certainly in the Health Security Act there is an escape valve there that nobody has mentioned so far, and that is, in a strictly rural situation it is very possible that a VA hospital may not have to close but can survive under a Title 38 type of operation.

Mr. STUMP. I thank you all for you answers, and I think you can determine by the questions that I have asked, I am extremely concerned that this is really going to hurt the Veterans Health Administration in the long run. I don't know that VA can be competitive, if they can't get their share of the dollars to do so, and when it comes to capital improvements, where is that money going to come from?

I guess in a way I hope I am wrong, but I still cannot see that this is going to work, and I am afraid it is going to be to our detriment. I just think that we bought on to some of the things in the beginning of the process that seemed like it was going to be good before we knew the details, and I hope they all get really ironed out and aired out before the final decision is made.

I thank you gentlemen, all. Thank you.

Mr. ROWLAND. Thank you.

I have one question I would like to ask Mr. Cullinan, and correct me if I am wrong. I think the VFW is opposed to taking care of dependents in VA facilities.

Mr. CULLINAN. Mr. Chairman, our position on that is, we don't want to see dependents brought into the system before veterans are fully accommodated. Even so, we realize this is an evolutionary process, and this means then that at a certain point in time, which will be hard to define exactly, veterans will be deemed accommodated and dependents should, and hopefully will, be brought into the system.

Mr. ROWLAND. Using excess capacity.

Mr. CULLINAN. Excess capacity and the money that they themselves will bring with them. We don't see them just coming into the system empty-handed, so to speak. They are going to be bringing their insurance dollars, just as if they went to any other provider. So we see that eventually being advantageous in two ways. They are going to be bringing nonappropriated dollars into the system, and they are going to be improving the patient mix and numbers so that hopefully VA will function more efficiently as well as effectively.

Mr. ROWLAND. I assume that is essentially the position of the other VSO's who are represented at the table here on dependents. Okay.

Ms. Long.

Ms. LONG. I don't have any questions, Mr. Chairman.

Mr. ROWLAND. All right.

There will be some questions we will submit for the record. I want to thank all of you for appearing here this morning.

[The questions and answers appear at p. 196.]

Mr. ROWLAND. Our third panel consists of Dr. Samuel Spagnolo, National Association of VA Physicians and Dentists; Ms. Bette Davis, who is president of the Nurses Organization of Veterans Affairs; and Ms. Alma Lee, who is president of the VA Council of the American Federation of Government Employees; Charles Prigmore, senior vice commander and legislative chairman of Ex-Prisoners of War, U.S.; and Mr. Paul Egan, executive director of the VVA.

We would ask that you limit your oral testimony to 5 minutes, and your entire statement will be made a part of the record, and we will start with Dr. Spagnolo.

STATEMENTS OF SAMUEL V. SPAGNOLO, M.D., PRESIDENT, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS; BETTE L. DAVIS, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS; ALMA LEE, PRESIDENT, VA COUNCIL, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; CHARLES PRIGMORE, Ph.D., SENIOR VICE COMMANDER AND LEGISLATIVE CHAIRMAN, AMERICAN EX-PRISONERS OF WAR, INC., ACCOMPANIED BY WILLIAM E. BEARISTO, NATIONAL COMMANDER; AND PAUL EGAN, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

STATEMENT OF SAMUEL V. SPAGNOLO, M.D.

Dr. SPAGNOLO. Thank you, Mr. Chairman. I am delighted to be here to speak as President of the National Association of VA Physicians and Dentists.

I have found this morning's session very informative, and I am pleased to have the opportunity to appear here today as you begin your deliberations about our Nation's health care system.

The VA medical system provides services to more than 20 million outpatients and nearly one million hospital inpatient visits each year. However, it is a system that is in trouble.

To quote Chairman Montgomery who wrote recently in our NAVAPD newsletter, and I quote, "The VA faces a number of health care delivery problems that stem from more than a decade of deficient medical care budgets."

In short, the VA system has reached the limits of even our dedicated professionals' ability to do more without the necessary resources, and in the midst of this we are now faced with the insecurity stemming from the potential for enormous change due to health care reform and changes in the nature of the veteran population. I am sure that you share in our concern.

We are currently reviewing and evaluating the numerous proposals for health care reform. Unfortunately, none are particularly detailed about where and how the current VA health care structure is integrated and financed by reform.

Before the members of this committee make recommendations regarding the impact of health care reform, we think there are some issues yet to be fully evaluated. Let me illustrate. We currently serve about 10 percent of the veteran population. The acute care work load is decreasing annually and inpatient census is decreasing. Our veterans are aging, as are all of us, but veterans will even be older. For example, 50 percent of all living veterans are older than 56; 10 percent of all VA patients today are over 75 years old.

From these projections, one out of every four VA patients will be over 75 by the year 2010, and they will be living in only seven predominantly sunbelt States.

It is also important to note that several studies have suggested that the employer-mandated health care reform packages that are currently being discussed are expected to decrease VA inpatient demand by at least 20 percent and some say as much as 50 percent.

Clearly the medical needs and problems of future VA patients will be different. Our areas of concern fall into four simple categories: Access and eligibility, quality of care, financing, and restructuring. All our assumptions rest on the fact that you will de-

termine that the primary responsibility of the VA system will be to continue to serve the needs of veterans who have service-connected disabilities and/or low income.

First, access to VA care should be revamped by simplifying eligibility. However, we would not like to see more layers of bureaucracy in order to do this.

Second, patient care should be improved by developing affiliations with medical schools if necessary, increasing sharing agreements, and creating centers of excellence primarily for those areas where we currently do a very good job, some of which you have already heard this morning, such as spinal cord injury, prosthetic research and rehab, mental illness, substance abuse, and long-term care. There should be some emphasis on geriatric units as well.

The VA also has some of the best medical research and training in the world, and NAVAPD feels strongly that the VA commitment to medical research and education for health care professionals continue. These vital missions play an important role in maintaining the quality of patient care as well as retaining outstanding physicians and dentists and other health professionals.

However, the time has come when Congress will have to decide to improve these activities or possibly shut them down unless adequate resources are identified to pay for them.

Third, steps should be taken to increase flexibility and rationality of resource allocation within the hospitals. We support the principle of reimbursement based on services provided just as in the private sector and that resources be distributed based on productivity and quality of service.

Finally, even while the number of veterans is shrinking, many individuals may wait weeks for vital services. For the VA to survive, it must not only upgrade equipment and physical surroundings, it must rid itself of the institutional mind set that has bred bureaucracies that clog and distort the decision-making process. VA physicians and dentists fear that managed care means simply more of the same management and less care. Physicians and dentists of the VA support any effort to improve the quality of patient care within the resources available.

I thank you for the opportunity of being here and would be willing to answer any questions.

[The prepared statement of Dr. Spagnolo appears at p. 162.]

Mr. ROWLAND. Thank you.

Ms. Davis.

STATEMENT OF BETTE L. DAVIS

Ms. DAVIS. Good morning, Mr. Chairman. I am Bette Davis, a clinical nurse specialist at the Washington, D.C. VA Medical Center and President of the Nurses Organization of Veterans Affairs.

Thank you for inviting NOVA to testify today. We appreciate the opportunity to work with your subcommittee and acknowledge the chairman's long-standing record and commitment to veterans' health care.

Specifically, NOVA applauds the President's plan for the VA to continue as an independent health care system managing VA health plans within regional health alliances which will provide a comprehensive national benefits package to all veterans who enroll

in the VA plan. It will enable the VA to focus on primary preventive care and health promotion across the life-span of veterans, with services delivered in community-based settings.

Clinton's plan will simplify eligibility rules and restructure the VA for equitable health delivery arrangements. It will increase VA's ability to compete in providing a comprehensive package of benefits with no lifetime limits on the coverage.

Today's VA system cannot attain reimbursement from Medicare or private insurance for all veterans' care and is entirely dependent upon Federal appropriations for funding. Under the President's proposal, the VA health system will have access to additional funding sources such as employer contributions and Medicare reimbursements. None of the other legislative proposals for health care reform provides additional resources for the VA medical system.

The administration's plan recognizes that primary and preventive health services are crucial to any restructuring of health care delivery. The single most important change in the VA health system will be to move from an emphasis on an illness-care cure modality to a continuum of care that provides primary and preventive care services. Under the proposal, the health care setting could be restructured and reoriented for services to be available in community settings as well as in institutional settings.

The core of the health care reform plan is the use of managed care services which are utilized to integrate, coordinate, and advocate the delivery of health care for individuals with primary care as its focus. It also focuses on wellness and preventive care, not rationing, to cut costs.

Health care reform will reinforce the role of nurses as providers for primary/preventive care, acute care, mental health care, and long-term care in multiple settings such as ambulatory care, acute care, geriatric, and long-term care facilities, and homes. Primary health care providers focus on managing current health care needs, preventing future problems, and referring to other providers and specialists when appropriate.

NOVA is pleased that the VA is developing and moving toward a managed care environment with primary care as its focus. We believe a significant investment initially will enable the VA to restructure and change distribution of VA resources, enhancing our ability to deliver primary care and improve the physical infrastructure of many facilities. Any cuts for startup and continual programs will severely affect VA's ability to compete.

Most Americans probably prefer to select their own provider of health care if given a choice, but more are likely to enroll in managed care plans instead of fee for service plans because of escalating costs. Even now, insured veterans, including those with Medicare, utilize both VA and non-VA resources for care.

Of the one-fifth uninsured Americans, 85 percent of them are workers with families. Not all veterans are homeless, derelicts, or substance abusers as portrayed in the media myth of veterans. A survey of the Dayton, OH, VA medical center reveals that 68 percent of their outpatient population is married with another 14 percent living with a significant another or relative.

With improved access and a comprehensive approach to primary care, veterans' demand for VA health care should increase. If veter-

ans' spouses (collaterals) belong to the same plan, it greatly enhances the care for both. VA's aging population with its multiple health problems could be served better, at least initially, if both the veteran and spouse were seen on an outpatient basis or at home.

Mr. Chairman, NOVA believes that, overall, the administration's proposal will enable the VA to be an improved independent health care system fulfilling its original mission of providing comprehensive health care. There is a mammoth job ahead of us which will proceed in phases. All the hopes and concerns about VA's participation in national health care reform can't be addressed in one hearing.

Mr. Chairman, we are pleased to have your leadership and skills in our mutual effort to influence progress and ensure quality health care to U.S. veterans. We look forward to working with you now and in the future to make the VA health care system an even better national model of health care than it is today.

[The prepared statement of Ms. Davis appears at p. 165.]

Mr. ROWLAND. Thank you very much.

Ms. Lee.

STATEMENT OF ALMA LEE

Ms. LEE. Mr. Chairman and members of the subcommittee, my name is Alma Lee, and I am the President of the Veterans Affairs Council of the American Federation of Government Employees, AFL-CIO, AFGE.

On behalf of the 125,000 employees of the Department of the Veterans' Affairs, our unions represent, I thank you for the opportunity to testify here today on the role of the VA in national health care reform.

AFGE supports the general approach to reform of our Nation's health care system embodied in the President's Health Security Act. In particular, we applaud its core principles of universal coverage, progressive financing, meaningful cost containment through global budgeting, and government coordination of allocation of health care resources. Within this context, AFGE believes that if certain steps are taken, the VA can have an important and expanded role to play in our Nation's health care delivery system.

We believe that this plan holds great potential for the VA because it will allow greater public access to our excellent health care facilities but it will also put pressure on the DVA to improve conditions in many veterans' hospitals and outpatient clinics so that we will be able to compete successfully.

The stakes are high because if the VA medical center does not succeed in the marketplace, there is likely to be tremendous pressure to dismantle the system, sell assets to private sector providers, and reduce the Government's role in providing health care to veterans through nothing more than the provision of subsidies to private providers. AFGE believes that the latter scenario needs to be taken seriously because we know first-hand how difficult it is to achieve change which puts patients first in many VA facilities.

We caution those who believe that the VA can be a successful competitor by maintaining current operating procedures. The argument which supports this position claims that the VA already has an advantage over competitors because it is accustomed to adher-

ing to negotiated annual budgets. They believe that private sector competitors who have operated with the blank check of treating those with traditional indemnity insurances will at least take time to adapt to the reality of cost containment.

AFGE believes that this is a false and dangerous confidence. We strongly support the maintenance of a separate veterans' health care delivery system. We believe that not only do veterans deserve to have their health care needs occupy a privileged position in the Nation's health care budget but also that only a separate system will provide the specialized and often unique types of care that veterans need.

But even as a separate system which has not faced full blown competition from the private sector for patients, the VA health care system has been struggling.

AFGE has appeared before this committee repeatedly to describe the impact of budget cutting over the past decade. Staffing levels are dangerously low in many VA medical centers, and we have lacked the funding to provide adequate access to the latest medical technology for treatment and diagnosis.

I believe that when the DVA is forced to compete with the private sector for patients, pay and working conditions for nursing and support staff will have to be improved in order to attract veterans who will be able to go elsewhere at a similar price.

AFGE is hopeful that competitive pressures along with President Clinton's reinventing government initiative will induce the DVA to reallocate resources to improve staffing on the level of patient care and reduce unnecessary levels of management who are not involved in patient care. The insulation of the VA medical centers has allowed them the luxury of vastly bloated management ranks and administrators who have seemed indifferent to the quality of patient care.

AFGE hopes that national health care reform in tandem with President Clinton's advocacy of a partnership approach to reinventing the way government operates will produce revolutionary changes in labor-management relations in the DVA.

AFGE believes that the President's plan for national health care reform holds the potential to improve greatly both the quality and quantity of health care services the DVA provides. The DVA will have to change its resource priorities.

Thank you.

[The prepared statement of Ms. Lee appears at p. 172.]

Mr. ROWLAND. Thank you very much.

Before I recognize Dr. Prigmore, I wish to recognize Mr. William Bearisto, who is the national commander of the American Ex-Prisoners of War.

We are really pleased to have you here. (Applause.)

I had the opportunity 2 weeks ago, Mr. Commander, of being in Valdosta, Georgia, when the Georgia Chapter was having its annual meeting and had the honor of being asked to address that group, and it was a real good occasion.

Thank you very much.

Dr. Prigmore.

STATEMENT OF CHARLES PRIGMORE, Ph.D.

Mr. PRIGMORE. Mr. Chairman and members of the subcommittee, I am Charles Prigmore, national senior vice commander of the American Ex-Prisoners of War.

I would like to say in preface that we agree with the chairman in his remark at the beginning of this hearing that we must preserve the strengths of the VA system. I want to underline that and say I thought that was an excellent way to begin this hearing.

We support the following considerations regarding the VA's role in the national health plan: One, the present system of VA hospitals and community facilities should remain intact in recognition of the unique health needs of veterans, such as exposure to Agent Orange, the 15 presumptions of ex-POW's, and so forth.

Veterans' health needs require programs specifically oriented to their treatment. The United States Government has consistently indicated its responsibility for health care of veterans.

I might say in passing that the VA not only has the duty of providing health care to veterans, but it has a secondary obligation for caring for servicemen and women returning from combat duty usually overseas.

Secondly, no financing of veterans' health care should come from employers. This is particularly true of veterans with service-connected disabilities and former prisoners of war. It is the Federal Government's obligation to furnish free care to service-connected veterans and former prisoners of war.

Third, no nonveteran should receive health care from VA facilities. These facilities should remain specifically for care of veterans. Of course, this would include military personnel who will shortly become veterans.

Fourth, service-connected veterans and former prisoners of war should receive a continuum of care from prevention, outpatient care, hospital care, nursing home care, in-home care, and domiciliary care on a basis of right rather than Government discretion.

Five, VA facilities should be more adequately funded in order to provide such quality services as I have just mentioned.

And, lastly, we question the desirability and feasibility of having the VA compete with other health plans for the care and treatment of veterans. Some competition occurs now and perhaps always will occur, but present competition allows the veteran to select only eye care, for example, from private hospitals but retain the VA for all other care. The national health plan would seem to force the veteran to make an overall choice. If this one-time overall choice is the plan, we oppose it.

The American Ex-Prisoners of War is dedicated to a Veterans' Administration health care system that is separate and distinct from the national health care system. It should not be absorbed in the national health care system. It is a benefit that is earned by the veteran and should not be subject to choice.

As Senator Rockefeller has recently stated, on a day when we honor our veterans for the sacrifices they made for our country, let us remember our commitment to them by renewing our promise to provide the high-quality health care that they have earned.

We are encouraged by Secretary Jesse Brown's pledge to keep quality improvement programs in place and his statement that VA

can make good on its claim to serve as a national model of efficiency. We urge the Congress to retain the strengths of the VA system to provide better funding and to maintain the Nation's commitment to its veterans.

Thank you, and I will be happy to answer any questions.

[The prepared statement of Mr. Prigmore appears at p. 177.]

Mr. ROWLAND. Thank you.

Mr. Egan.

STATEMENT OF PAUL EGAN

Mr. EGAN. Thank you, Mr. Chairman.

First of all, I would like to say, Mr. Stump, that the line of questions that you have asked of the previous panels are really very exciting from our standpoint because they are searching questions and they give the appropriate seriousness to this whole matter of what is going to become of VA health care in the event of a national health environment. I think it is important to suggest that every one of us—all of you on this committee and those of us in the organizations who have a stake in this system have to begin to think about the VA in ways that are different than we have become accustomed to thinking about the VA for a long, long time.

We have in the past assumed many things about the VA without really testing those assumptions. We have assumed that when the VA tells us its quality is good based on its outcomes research that, in fact, quality is really good. We have assumed that the medical school affiliations are just automatically of benefit. We assume that, with a captive audience of currently dependent users of the VA, that they are being pretty well treated.

We have to think now in terms of how we are going to test these assumptions, and we have to be very careful that the assumptions that we make are correct. In a competitive environment, we will know whether we were right in those assumptions.

Last year, the GAO as well as the Paralyzed Veterans estimated that as many as 50 percent of current users would depart this system. That means quality is a serious concern.

From our perspective, the Vietnam Veterans of America believes and always has believed that what is really important isn't necessarily the mortar and the brick of the system. What really is important isn't necessarily the employees of system. What is really important is the veterans the system was intended to serve, and those veterans, in our view, are deserving of a choice.

We believe that the VA system needs to be independent, that it can be independent, can continue to be independent, and the President's program for the VA does both of those things. None of the other national health programs that we have looked at offer the advantages, the extra advantages, that the President's program offers the VA system. It offers a new revenue stream, it offers veterans a choice that in many instances they have not had before, and it offers the VA an opportunity, a real opportunity, to demonstrate that it is what it has said it has been for many, many years.

The VA has got to do a couple of things. It first has to prepare to compete, and by that I mean that the VA has got to have access to the seed money that so many people previously have discussed. It has to have this new revenue stream created by incoming pay-

ments from health alliances that are in receipt of monies from both employees and employers, and, finally, it needs desperately to have a reliable expectation of appropriations.

We have seen as recently as the last several days the Washington Post article that the Office of Management and Budget has already begun what everybody expected they would do, which is to monkey around with estimates of how many paying customers the VA would attract and to begin to reduce the amount of money that would be requested in the upcoming fiscal year budget; very troubling.

If the VA is successful in competing, it will generate new and probably significant revenue from middle-class paying customers. If it fails to offer quality as defined by consumers as opposed to defined by doctors, researchers, and students, middle-class paying customers will not use this system. We know this to be true.

Veterans that use this system, apart from the service disabled and the low-income who will be eligible, have to be able to rely on the fact that they will be treated courteously, will be seen on time at appointments, that they will see individual physicians rather than a different student every time, and that there won't be repetitive and unnecessary diagnostic procedures for the benefit of teaching as opposed to the benefit of the veteran.

Accessibility, not only geographic but administrative accessibility, the maze of rules that governs who is eligible for what kind of care and what settings today makes it impossible and very discouraging for many veterans.

The VA needs a consumer orientation. Frankly, we are really very excited to see what is happening at least at the upper levels of the agency today, because, for the first time in many years, the VA is beginning to realize what competition is going to mean and the kind of change that that is going to entail.

We believe that in spite of the prospect of VA's either success or failure in a competitive environment, it must be positively sure that it does a couple of things. It can assure its permanency, at least to some extent, by doing more of what it does very well or better than the private sector today, and by that I mean it has got to continue and expand upon the work it is doing with the spinal cord injured, with the blind, the aging, the mentally ill, those that are involved with substance abuse, it needs to continue to serve the disabled in need of prosthetics devices, and perhaps more important than that or at least equally important, it has to find a way to fill voids that the private sector is not meeting, and one very good example of that is to begin to get serious about offering care in rural America, in unserved areas.

We think about VA oftentimes in the past from one perspective. We need a new paradigm. What was a legitimate argument in years gone by about whether or not dependents and nonveterans should use the VA system is almost an illegitimate argument today. Who among the middle class veterans who are going to be paying customers are going to subscribe voluntarily to VA if their dependents are unable to use this system?

I see that my time has expired and you are ready to gavel me off, but I think that there are some things that the VA can do. The

opportunities are there, and that is why we are so excited about this program.

[The prepared statement of Mr. Egan appears at p. 180.]

Mr. ROWLAND. Perhaps during the questioning you can make some additional points that you would like to make.

We are seeing in our country a change in the concept of the way that health care is delivered. We are seeing more emphasis being given to primary care, more emphasis being given to outpatient care. Any of you answer, or all of you, if you will. How is the VA going to best position itself to be involved in this changing concept that we see coming?

We will start with Dr. Spagnolo.

Dr. SPAGNOLO. I would be happy to try to answer that. I am not sure we yet know how we are going to handle primary care. I think we need a lot more of primary care in the VA.

There probably will be more of my nursing colleagues providing some of that primary care as well. How that will totally fit in I don't think anybody is quite clear, but we have got to be looking at that.

At the same time, we don't want to lose sight of the fact there are some outstanding specialists within the VA as well, and these two groups are going to have to work together.

Mr. ROWLAND. Ms. Davis?

Ms. DAVIS. Well, right now we are delivering primary care in—let me give you an example. There is a VA grant proposal pending in Ohio at the Wright State University with the Dayton, OH, Medical Center. They are proposing, now, to deliver home-based care to the veteran and the medicare eligible spouse, utilizing nurse practitioners who have joint appointments with the VA and the university, for primary care visits in the home, and for utilizing rural outreaching in underserved areas and rural areas as well as using the veterans' service organization mobile health care vans.

But I think that for primary care—the heart of it is prevention. If particularly, initially, the elderly spouse accompanying the veteran now to our centers, could be included—that is the smallest family unit—the couple itself. The wife usually does come—she is the one who gets the information, reducing health risk factors; she is the one managing the care at home, preparing the food, administering the medications. She is preventing hospitalization, further complications, and promoting wellness. All of that is primary care. And now, with the choice of enrollment, especially if they are both eligible for Medicare, it would behoove the VA to include them in the same plan, and then we can also continue our Centers of Excellence that are already in place, such as our GREC Centers, our GEM units, our HBHC programs, our day care programs, and a number of other specialized programs.

I will give somebody else a chance.

Mr. EGAN. If I understand your question correctly, Mr. Chairman, you are asking: How will the VA do in its dove-tailing relationship with the private sector?

Mr. ROWLAND. We see the change in the way that care is being delivered in our country now. We talk about more primary care physicians, more outpatient care.

Mr. EGAN. Excellent: That gives me a chance to address the one issue that I didn't quite get a chance to address, and that is the way in which we would envision—a reasonable way in which we would envision VA to participate in providing care in rural America, to fill that void that isn't being met.

VA has 171 hospitals. There is no reason why it can't be a parent facility for a whole variety of very small clinical operations or even mobile clinics.

Mr. ROWLAND. Are you talking about outreach?

Mr. EGAN. Outreach, absolutely. There is no reason why the medical school affiliations can't rotate people out to these places.

I don't know if you have traveled—a couple of years ago, I was vacationing in Maine, and I had a need to see a doctor, and I discovered something I was never aware of before. It was not an outpatient clinic in the usual institutional sense that you think of the VA. A colloquial term for what I found was what is called a "doc in a box."

I mean these are very small units that provide preventive, primary, and acute care, and there is no reason why these kinds of—I have to guess—very inexpensive kinds of facilities can't be created, if not by the VA alone, on a sharing basis with the private sector.

Obviously, if rural America isn't being served by the private sector or the VA, you are going to have veterans and nonveterans alike that need these services. A shared arrangement, perhaps much like what the VA does now in offering matching funds for State homes, arrangements that would permit a void to be filled that would assure a steady flow of users up the system into the hospitals and keeping it going. That is one way in which I see the VA can fulfill a very important need that is unmet anywhere today.

Mr. ROWLAND. You are suggesting that those outreach clinics might take care of people who are not in the VA system?

Mr. EGAN. If the facility were created as a result of monies from both the VA and the local community, certainly.

Mr. ROWLAND. Thank you.

Mr. PRIGMORE. I would like to emphasize, and I think we all recognize it, that home health care is far less expensive than hospital care, and let me just give a couple of quick ideas about that.

I have worked in communities that had extensive visiting nurse programs—and I think a lot of you have—where they go into the home and do the kind of preventive work that she talked about.

Another aspect I would like to throw out—for 8 or 9 years since I retired as a professor, I have been doing volunteer work at the VA hospital in Tuscaloosa, Alabama, and I have had a number of men that I have worked with as an educational therapist—I have had a number of men tell me, "This is the worst possible environment"—that is, not that particular hospital, but nursing homes in general, and they would tell me, "Don't ever end up in a nursing home if you can avoid it."

I think part of that is that they are not surrounded by any of their own possessions; they are in an alien, strange situation; a lot of times they don't have enough to do to productively occupy themselves. It is just simply not the best solution to the care of most of our veterans, and I would suggest that if we start developing in

the VA a much greater outreach program with home health care and prevention, we will save the Nation a huge amount of money. We will make life much more tolerable for these veterans that we are caring for now, and in every sense it is a better solution.

Thank you.

Ms. LEE. The VA has been looking at primary care for a number of years now, and we do believe that primary care is necessary and that in order to make the DVA more attractive to veterans whose medical care is more general, we must develop expertise in that medical field, and in order to do that, we must have money. So where does the money come from? We always look at how we can do these things?

The VA system has a habit of building. We really build a lot. We have a lot of middle management positions. We have an assistant to the assistant to the assistant at facilities. We need positions in direct patient care. Primary care is there. We should use it, and we should be looking forward and look to working at outreach programs to help the veterans.

Mr. ROWLAND. Thank you.

Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Let me thank all the members of the panel for their excellent testimony. I know it is late, but I would like to just ask a couple real quick questions.

Ms. Lee, the administration claims that current restrictions on contracting authority will be lifted. Do you believe there are sufficient limitations in place to prevent the VA from privatization through contracting?

Ms. LEE. Would you repeat that, please?

Mr. STUMP. Well, if the administration says they are going to lift the restrictions on contracting out, do you believe there are enough protections in place to keep the VA from privatization through contracting?

Ms. LEE. I do not think the VA should be contracting out. You are talking about contracting out, correct?

Mr. STUMP. I understand that, but do you think there are protections enough there to prevent that from happening?

Ms. LEE. I do.

Mr. STUMP. You do?

Ms. LEE. Yes. In the past the VA has done a lot of research into contracting out, and I do believe that, yes.

Mr. STUMP. But the administration claims they are going to lift those restrictions, that authority.

Ms. LEE. I know, and we oppose that. We oppose that because we feel we have the capacity and facilities to take care of the veterans.

Mr. STUMP. Thank you very much.

Dr. Spagnolo, let me ask you one question, or anybody if they want to answer. Do you believe the veterans under this plan are really going to benefit from the greater bureaucracy which adds at least an additional two layers of regulations to VA health care?

Dr. SPAGNOLO. Without repeating myself, we are not anxious to see more bureaucracy, and I cannot believe we are going to benefit

if we see another layer or two or three. We have got to get rid of some of the bureaucracy.

So that is a simple answer to your question.

Mr. STUMP. That is what I wanted. Thank you, sir.

Mr. Chairman, that is all I have.

Mr. ROWLAND. Thank you.

There will be some questions that we will submit to you for the record, and I want to thank all of you very much for being here this morning.

[Whereupon, at 12:18 p.m., the subcommittee was adjourned.]

APPENDIX

Statement of the Honorable Bob Clement
Before the Subcommittee on Hospitals and Health Care

MR. CHAIRMAN, THANK YOU FOR CONVENING THIS HEARING TODAY TO DISCUSS THE VA'S ROLE IN THE ADMINISTRATION'S NATIONAL HEALTH CARE REFORM PROPOSAL.

MR. CHAIRMAN, AS I ENTERED THE HEARING ROOM THIS MORNING I FELT THE BEST I HAVE FELT SINCE JOINING THIS COMMITTEE MORE THAN TWO YEARS AGO. IN LIGHT OF BUDGETARY CONCERNS AND OTHER PROGRAMMATIC CONSIDERATIONS, ALL TOO OFTEN THIS COMMITTEE MUST FIGHT TO PRESERVE VETERANS' BENEFITS. WE ARE FORCED TO CHOOSE BETWEEN THE LESSER OF TWO EVILS. IN SUCH CASES IT IS INEVITABLE THAT SOMEONE WILL BE PENALIZED.

UNFORTUNATELY, MR. CHAIRMAN, IN SUCH AN ENVIRONMENT THE MIRACLES THAT YOU AND THE OTHER MEMBERS OF THIS COMMITTEE HAVE WORKED HAVE GONE LARGELY UNNOTICED BY THOSE NOT DIRECTLY INVOLVED IN THE PROCESS. THUS, YOU HAVE NOT RECEIVED THE RECOGNITION WHICH YOU SO RIGHTLY DESERVE. AND THIS IS AGAIN EVIDENT IN THE AFFAIRS BEFORE US TODAY.

MR. CHAIRMAN, I KNOW THAT YOU, OTHER MEMBERS OF THIS COMMITTEE, AND THE VSO'S HAVE DONE AS I HAVE AND CONTACTED THE PRESIDENT, THE FIRST LADY, SECRETARY BROWN, AND ANYONE ELSE WHO WOULD LISTEN TO INSIST THAT UNDER ANY HEALTH CARE REFORM PROPOSAL THE VA'S HEALTH CARE SYSTEM RETAIN ITS AUTONOMY. THROUGHOUT

THE PROCESS WE WERE ASSURED THAT THIS WOULD TAKE PLACE. HOWEVER, I MUST ADMIT I JOINED THE VETERANS OF THIS NATION IN THEIR SKEPTICISM.

I WAS CONCERNED THAT WE MIGHT GET A SMOKE AND MIRRORS APPROACH TO VA HEALTH CARE AND HELD LITTLE HOPE THAT IT WOULD TRULY BE AUTONOMOUS. NOW THAT THE PLAN IS OUT, I CAN ONLY SAY
KUDOS TO THE FIRST LADY. THE ADMINISTRATION HAS MADE GOOD ON ITS PROMISE TO MAINTAIN THE VA HEALTH CARE SYSTEM AS AN INDEPENDENT SYSTEM FOR OUR VETERANS.

THEREFORE, MR. CHAIRMAN, I ENTERED THE HEARING ROOM TODAY WITH A LIGHT HEART. IT IS LIGHT BECAUSE FOR THE FIRST TIME IN RECENT MEMORY WE HAVE BEFORE US A PROPOSAL WHICH DOES NOT ASK OUR NATION'S VETERANS TO GIVE UP SOME CARE AND SERVICES OR TO PAY MORE FOR THE SERVICES AND CARE THEY ARE RECEIVING OR TO CONTINUE TO MAKE SACRIFICES FOR THE BENEFIT OF OTHERS.

THE PROPOSAL BEFORE US TREATS VETERANS WITH THE RESPECT AND HONOR WHICH THEY DESERVE. UNDER THE ADMINISTRATION'S PLAN, VETERANS ARE NOT ONLY TREATED FAIRLY AND EQUITABLY, BUT PREFERENTIALLY.

MR. CHAIRMAN, I AM NOT SO NAIVE AS TO BELIEVE THAT THE ADMINISTRATION'S HEALTH CARE REFORM PROPOSAL IS APPEALING TO EVERYONE. IN FACT, I A CERTAIN THAT THERE ARE MEMBERS OF THIS BODY AND EVEN THIS COMMITTEE WHICH JUST CAN'T WAIT TO GET UNDER THE HOOD AND FIX IT. BUT I BELIEVE YOU WILL BE HARD PRESSED TO FIND ONE TO SUGGEST THAT OUR NATION'S VETERANS COULD HAVE GOTTEN A BETTER DEAL THAN THEY GET UNDER THE ADMINISTRATION'S PLAN.

NOT ONLY WILL THIS PLAN ALLOW THE VA SYSTEM TO REMAIN INDEPENDENT BUT IT WILL ALSO CERTAINLY IMPROVE THE CURRENT VA HEALTH CARE SYSTEM.

AGAIN, MR. CHAIRMAN, THANK YOU FOR HOLDING THIS HEARING. I LOOK FORWARD TO HEARING FROM THE WITNESSES.

STATEMENT OF

THE HONORABLE JESSE BROWN

SECRETARY OF VETERANS AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEATH CARE

HOUSE COMMITTEE ON VETERANS AFFAIRS

October 14, 1993

Mr. Chairman and Members of the Committee:

Thank you for giving me this opportunity to discuss with you the President's plan for National Health Care Reform. We believe that the Department of Veterans Affairs health care system will be strengthened by the President's proposal.

Mr. Chairman, the President and the First Lady have indicated their wholehearted support for the VA health care system. I was a member of Mrs. Clinton's Health Reform Task Force. VA staff participated fully in all of the work groups that were formed to address issues and develop material for the President's plan. The opinions and expertise of VA staff who participated were an integral part of the process and are reflected in the final proposal. The First Lady also met with representatives of the Veterans Service Organizations.

The President's plan for national health care reform provides security for all Americans by ensuring universal, affordable health care coverage. The proposal guarantees

all Americans access to comprehensive health benefits including prescription drugs, outpatient services, prosthetics, hospital and respite care, and preventive health services. No American can be denied coverage because of a pre-existing medical condition. All Americans will have the freedom to choose the provider or health plan that best suits their needs. We believe that the VA is in a position to be the clear choice for many veterans and is uniquely suited to continue to meet the needs of our Nation's veterans.

We also believe that the President's plan incorporates features that will preserve and strengthen the VA health care system. We cannot afford to let this golden opportunity slip through our fingers.

Mr. Chairman, the VA today operates the Nation's largest centrally managed health care delivery system. Its capabilities encompass the full continuum of medical care, from primary care and sophisticated tertiary services to rehabilitation and long term care. The magnitude of VA's role in the current national health care environment is reflected in the following statistics:

- we operate 171 medical centers and over 300 clinics nation wide;
- we employ over 205,000 professional, technical and support staff;
- we provide a million inpatient episodes of care and more than 23 million outpatient visits annually;

- we provide special services for veterans with expertise in spinal cord injury and PTSD treatment; and
- we educate and train over 100,000 health care professionals annually.

Today's VA, though, faces considerable constraints and pressures from many obstacles. These impediments must be surmounted in order for VA to survive and maintain its capability to fulfill the Nation's obligation to its veterans. In the VA system today:

- we have patients who are disproportionately older, sicker, and have lower incomes than the population as a whole;
- we are entirely dependent upon Federal appropriations for funding;
- we cannot obtain reimbursement from Medicare or private insurance for all veterans care;
- we are required to follow confusing and complex rules and laws in providing patient care; and
- we are subject to the severe impact of medical supply and service costs.

The President's proposal for the VA health care system under national health reform is designed to preserve the outstanding contribution of the VA to the Nation's health care, while offering some proposed solutions to the array of problems the VA currently faces. Under the President's proposal the VA system is embraced as a key component in national health care reform yet

retains its central commitment to the nation's veterans. Under the proposal the VA will become a viable health care choice for millions of veterans who, today, are unable to access the current VA system.

Under the President's proposal, VA will organize and manage VA Health Plans throughout the Nation. VA Health Plans would be offered as an enrollment choice to all veterans who live in the geographic areas covered by the plans. The VA Plans would guarantee all veterans who are enrolled the same comprehensive standard benefits, including comprehensive outpatient care that other plans will provide their beneficiaries. As a result, the President's proposal will simplify eligibility criteria for VA care. Veterans enrolled in a VA Plan would benefit from VA's experience and long history of treating the diseases and health problems faced by veterans. Moreover, participation in a VA plan would provide them with access to the Nation's premier consultants and clinicians already within the system and through the VA's affiliation with outstanding medical schools nationwide. The VA plans will meet Alliance requirements regarding quality and reporting.

Service-connected and low-income veterans enrolled in a VA Plan would continue to receive free care from the VA and would not be subject to any cost sharing for care they receive. Higher income nonservice-connected veterans would be required to make modest copayments for care under

the same rules that apply to other health plans.

Furthermore, service-connected and low-income veterans would continue to be eligible for free care from the VA for a number of medical services which VA has traditionally provided to its patient population, such as long term care. VA would have the option of offering supplemental benefits not covered by the standard benefits to higher income, nonservice-connected veterans for an additional premium payment through the VA Health Plans.

Another important change for us is that the proposal gives the VA health system access to additional funding sources. VA facilities would be able to provide services on a reimbursable basis to veterans who are members of other health plans and to higher-income, nonservice-connected veterans with Medicare coverage. And let me take this opportunity to clarify some misconceptions about Medicare reimbursements. Medicare reimbursements would open up the VA system to those veterans who would prefer to come to VA for care but are now shut out. Please keep in mind that the Medicare funding those new veterans bring with them would be spent regardless--whether they are treated by VA or another provider. The beauty of this new opportunity is that it provides a wider array of options to veterans than they currently have and is cost neutral to the government. With respect to veterans who now use VA services, Medicare may reimburse VA for services that Medicare now does not pay for. The details of Federal

payment standards for Medicare, VA, and CHAMPUS will be developed before the final plan is presented to Congress.

The VA could also receive premiums from the Health and Corporate Alliances on behalf of all individuals enrolling in the VA Plan. This major new funding source would allow the VA system to be less dependent on appropriations from the Congress and would put the VA on a more level playing field with other health plans. With access to alliance payments, VA can offer care to more veterans. In addition, the proposal specifically allows VA to retain these payments to be used for investment in further care for veterans and improvement of the VA system. The proposal also allows the VA to retain all collections and reimbursements including those from other plans and, for the care of higher-income nonservice-connected veterans, from Medicare. Thus, VA would be dependent on appropriations only to cover the cost of the veterans' share of standard health care benefits for service-connected and low-income veterans and for medical services to these veterans that are not covered by standard benefits.

Mr. Chairman, we recognize that VA has to make many changes and improvements in its health care delivery system to make this proposal work. To compete successfully with the other health alliances, we will have to restructure portions of our organization, will have to modify some of our financial operations, and will have to

expand the scope of our medical care delivery system to provide basic primary and ambulatory care services. As you already know, we are looking closely at creating and solidifying medical center networks and at developing a managed care environment with primary care as its focus. I welcome the challenge of leading VA into the twenty-first century as a strong, independent, provider of high quality care to our Nation's veterans--to whom we are all beholden. We have many of those implementation steps in progress. For example, we are actively pursuing more formalized referral and care delivery networks, and we are improving our managed care program and enhancing our primary care delivery system. The President's proposal also calls for the establishment of a revolving fund from which VA may borrow to finance one-time start up costs of our health plans, including making needed improvements to the physical infrastructure of our facilities.

We believe that this proposal ensures a fiscally sound VA health care system that will permit the VA to remain a viable, independent organization committed to improving veterans' health care and treating medical problems unique to military service. The VA system will be able to continue its support of research in basic science, clinical applications and health systems, and in medical and associated health education and training. This proposal also would ensure the VA's ability to continue to serve as back-up to the Department of Defense

in case of war or other national emergency.

I am confident that VA's participation in national health care reform will allow the VA system to prove that it can be a model for the successful integration of outpatient, acute and long term care. VA's experience in managing a health care system within a fixed, global budget will be an example for other plans.

Mr. Chairman, I cannot state strongly enough our willingness to work with you to address points in the plan that may not be clear and to answer questions and to develop a legislative package consistent with the President's goals that will be enacted. I believe that the President's proposal preserves the VA health system for the Nation's veterans and, for the first time in history, provides the means to allow all veterans access to their system.

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

Thank You, Mr. Chairman.

First, let me take this opportunity to commend you for holding this important hearing today. I would also like to take a moment to welcome Dr. Marvin Dunn, Dean of the University of South Florida College of Medicine.

Since the President announced the details of his "Health Security Act," I have heard from many veterans who are confused and concerned about its impact on the VA health care system. I must say that I share their concerns.

Although I have long advocated an increase in funding for the VA health care system, I am not convinced the Administration's legislation will bring additional funding into the VA system. Florida has one of the lowest levels of discretionary care in the country. This means that higher income veterans would be unable to receive medical treatment at the VA. This begs the question—why would a veteran who has already been turned away from the VA choose it as his or her health care provider?

If the VA in Florida is unable to attract a significant number of higher income veterans, what will happen to VA hospitals in my home State? Will veterans be forced to go elsewhere for their care?

Currently, Florida receives approximately $600 million for VA health care each year. I have been informed that in order for the VA in Florida to provide the same level of services available in other States, it needs an additional $400 to $500 million per year in operational expenses. This additional funding does not include the backlog of construction projects planned for the State.

What worries me is that these types of fiscal constraints are found throughout the VA system. Unless this issue is addressed up front, the viability of the entire VA health care system is threatened.

The VA health care system is a national asset, and I am committed to ensuring that it continues to be one. The men and women who have served in our armed forces have met their obligations to our country. As we move toward reforming the Nation's health care system, we must show our veterans that they have not been forgotten or abandoned.

I have said this before but I think it deserves repeating, the veterans' service organizations that are in the audience this afternoon need to remain vigilant. The health care debate is far from over, and it is imperative that you continue to be active players in the ongoing deliberations on health care reform.

Mr. Chairman, as always, I look forward to working with you and the other members of the committee on this important issue.

Thank you.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Robert G. Petersdorf, M.D., President

THE ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS AND MEDICAL SCHOOL AFFILIATIONS IN HEALTH CARE REFORM

Presented by:

Marvin R. Dunn, M.D.
Dean
University of South Florida College of Medicine

before the:

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives
Representative J. Roy Rowland, Chairman

334 Cannon Office Building
Thursday, November 18, 1993
9:30 AM

2450 N STREET, NW
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Good morning, Mr. Chairman and Members of the Subcommittee. I am Marvin Dunn, M.D., Dean of University of South Florida (USF) College of Medicine. On behalf of the Association of American Medical Colleges (AAMC), I appreciate the opportunity to testify this morning on the role of the Department of Veterans Affairs (VA) and medical schools in reform of the national health care system.

The AAMC serves as the national voice for the country's 126 accredited medical schools, over 90 professional and academic societies, and 400 major teaching hospitals, including over 70 VA medical centers. In my own case, I have had the privilege of being associated with five VA medical centers (VAMC) over the span of my 34 years in academic medicine. These include the VAMC's in Philadelphia, San Diego, San Antonio, Bay Pines, and Tampa. As interim dean, I chaired the VA-Medical School conjoint Dean's Committee in San Antonio and Tampa. I came to Tampa in 1988 initially as a full-time VA employee, as the Associate Chief of Staff for Education, serving both the James A. Haley VA Hospital in Tampa and the Bay Pines VAMC. In 1991, I became dean of the USF College of Medicine.

The development of the USF College of Medicine demonstrates the important, symbiotic link between the VA and medical schools. USF began with an agreement between the state of Florida and the VA. The State of Florida opened a second medical school within the state university system in 1971 in Tampa. The VA built a new hospital, the James A. Haley VA Hospital, directly across the street at the same time. The two institutions, connected by a covered pedestrian bridge over the street, have worked cooperatively in mutual support and benefit for the past 22 years as originally planned.

This example illustrates the history and level of cooperation between the VA and U.S. medical schools. As I described, these mutually beneficial arrangements were initiated with Federal support, based on an understanding of the benefits accrued to both veterans and the nation by virtue of the linkage with academic medicine. Over the years, the VA has built a large number of its hospitals in close physical and functional relationships with their affiliated medical schools. During the 1970's, several medical schools began with direct support of the school itself by the VA.

The VA operates a sophisticated health care system that makes major contributions to the health of veterans and to the national health care delivery system. In order to consider how the veterans health care system fits into the overall U.S. health care system, and the role the VA should play in health care reform, it is important to understand the various responsibilities of the VA and its multiple missions. The VA health care system has four statutory missions: providing clinical care to eligible veterans, training health care professionals, conducting research, and serving as a back-up to military medicine during war or national emergencies. The VA carries out its missions through a network including 171 hospitals, 350 outpatient clinics, and over 150 nursing home and long-term care facilities. In 1992, VA professionals provided inpatient hospital care to more than one million veterans and completed nearly 25 million outpatient visits.

In part, the education and research mission assist the VA in meeting high quality standards in the primary mission of providing health care to veterans. The VA's missions of education and research are implemented through the type of partnerships between VAMCs and medical schools to which I previously referred, commonly referred to as "affiliation agreements." Affiliations between VAMCs and medical schools, or Dean's Committee affiliations, greatly enrich the patient care environment of VAMCs and enhance the educational and research programs of the medical schools. The policy to establish affiliations was developed in 1946 in a document, called "Policy Memorandum 2." This document describes the purpose of affiliations as "affording the veteran a much higher standard of care than could be given him with a wholly full-time medical service."

Affiliations improve immeasurably the quality of care by enabling the recruitment and retention of talented professionals and by creating an intellectually challenging and dynamic environment that shapes the general ambience of the VAMC. Since 1946, the VA has also developed linkages to participate in training a variety of other health care professionals, including nurses, dentists, and pharmacists. Each partner in an affiliation shares a common goal: a quality health care environment that is not only good for veterans, but essential for high quality education and improving the health of the nation.

While affiliations were designed to improve the quality of care delivered to veterans, the partnership has also brought substantial benefit to medical schools and their broad societal

missions through educational and research opportunities resulting from serving a diverse and often medically-complicated patient population. Affiliations also allow for cost-effective and efficient sharing of clinical and research resources. This presents enormous positive opportunities in the implementation of health reform and the subsequent local planning that will occur. I will comment further on this last point in a moment.

The following statistics demonstrate the breadth of the partnership between medical schools and the VA:

- 102 of the 126 U.S. medical schools are affiliated with at least one VAMC;
- Over 130 of the nation's 171 VAMCs have an academic affiliation;
- Each year, more than 30,000 medical residents (approximately one-third of all residents) and 22,000 medical students (nearly one-third of all medical students) receive a portion of their education in a VA clinical setting;
- VA funds 10 percent of all U.S. residency positions annually (about 8500 slots); and
- Half of the practicing physicians in the U.S. have spent some time training in the VA system.

As partners, the VA and academic medicine should approach the challenges of health care reform with the principles of quality, efficiency, and cooperation in mind. In other words, how can we work together to preserve and promote the historically strong, cooperative relationship between the VA and medical schools? Two major challenges face us as we move toward health care reform. First, many observers characterize the emerging health care system as involving increased competition for patients and revenue. Second, the level of government regulation in the VA complicates partnerships with non-Federal health care providers. In addition, the VA must plan carefully to preserve its mission as a support system to the Department of Defense (DOD). The importance of this mission is heightened as DOD begins to down-size and to close bases.

From the perspective of the AAMC, two primary factors underlie the range of options which can be considered for reforming the VA health care delivery system. The first factor is the population to be offered services within the VA system. The second factor is the set of services which will be provided by the VA health care delivery system. Both of these factors are inter-woven with options related to reform of financing for the VA health care delivery system.

Revising the eligible patient population should involve opening the VA to veterans other than those currently entitled to mandatory care. Current rules require a veteran to have service-connected disabilities or to meet a means test in order to be considered an "entitled" or "mandatory" patient for whom the VA must provide services. Other veterans are considered "discretionary" and may receive care from the VA on the basis of locally available space and resources.

Opening the VA to veterans beyond the current population would be especially appropriate for facilities with additional capacity and particularly where the facility is also located in medically underserved area. For the newly eligible cohort of patients, the VA must be permitted to bill insurers for the costs of their coverage. As a qualified health plan, the VA could also develop mechanisms to provide access to care for veterans' dependents. This scenario is applicable in the context of the reform plan proposed by President Clinton, as well as in a number of other broad policy frameworks, based on the principles of market competition.

With respect to the set of services offered by the VA, it is currently projected that the veterans population will continue to age and to decline in absolute numbers. Over time the VA system could be 'right sized' to reflect this diminishing and changing patient population. Alternatively, planning could focus on the evaluation of certain services which veterans could receive outside the VA system. This option could direct the VA to focus on services of special import to veterans, or areas in which the VA has developed special expertise, including mental health, geriatric medicine, long-term care, and rehabilitation for spinal cord injuries or loss of limbs, and to arrange coverage for other types of services through networks or contracts. Such networks or contracts could most readily be developed based on the existing partnerships between the VA and academic medical centers as well as the DOD. I will return to the development of networks in a moment.

For purposes of this discussion, specialized areas can be divided into two categories -- those which will remain particularly important to veterans and those which will become increasingly important to the general population. The veteran population has unique demands for rehabilitation and mental health services, in many cases related directly to military experience. The extent and breadth of care in these areas is unlikely to be as

relevant for the general population as for the veteran population. On the other hand, in areas related to aging, the VA has developed its expertise because of patient demographics that will generally become more critical to the entire health care delivery system as the general population ages.

As I mentioned, to assure enrolled members comprehensive coverage and an appropriate range of high quality services, the VA should employ locally-arranged linkages rather than attempt to create the capability to provide all services. The most likely and effective partners in such arrangements would be DOD and academic medical centers, based on many long-standing, cooperative arrangements. The hospital shared by the VA and the Air Force in New Mexico is an excellent example of successful cooperation between VA and DOD.

In my own community, the potential for a similar productive partnership exists between the VA and the Navy. The VA has recognized the extraordinary growth of eligible veterans in Florida in contrast to other areas of the U.S. and plans to develop a new hospital in Orlando to address this pressing need. Currently, Orlando is served by an overburdened outpatient center staffed and supported by the James A. Haley VA Hospital in Tampa. After much confusion over the exact site in Central Florida to construct the new VA hospital, we are pleased to note that the VA has exercised sound planning and is looking to utilize the existing hospital facility on the Naval Air Station site that is being decommissioned.

Other opportunities exist where VA expansion needs can be met with cooperative planning by using over-capacity of DOD or even the private sector. Sharing between current VA hospitals demonstrates the value of such cooperation. USF's two VA affiliates, Bay Pines and Tampa, are located 38 miles apart, but share many common services. For example, they have only one laundry, one radiation oncology department, one spinal cord injury unit, and one open heart surgery program. In addition, some services are integrated, such as the rehabilitation program, run by a single nationally-recognized director. The private sector can learn a great deal from the VA regarding efficiencies through shared resources. Moreover, the VA could expand intra-VA sharing as well as sharing with academic affiliates.

VA partnerships with academic medical centers promote cost savings and efficiencies in the same manner as VA-DOD sharing arrangements, through features such as shared equipment. Such features will become even more attractive and critical as the nation moves toward an increasingly competitive environment for health care delivery and financing. While a competitive market is specifically called for in reform plans proposed by President Clinton and other policy makers, those of us in health care administration have already begun to experience the forces of market competition. I would argue that with or without enactment of national health care reform, all of us will continue to face the challenges of increasing competition for patients. For the VA, this phenomenon calls for expanding VA's ability to participate in networks, especially given the demographic data which projects a decline in the veteran population. Networks will also assist the VA's ability to provide appropriate, comprehensive care, especially for newly eligible patients, such as veterans' dependents.

Decisions about financing the system should flow from decisions made about the patient population. In general, it makes most sense to retain federally-supported VA coverage for veterans who are currently eligible and to expand access to the VA for other population groups. The new populations must be required to reimburse the VA through their insurance plans and remit any appropriate individual copayments.

In pursuing reform of the VA, Congress will need to consider the ramification of various options for the existing relationship between the VA and academic medicine. Affiliation agreements with medical schools currently play a vital role in assuring the provision of high quality care to veterans. The success of this role in promoting quality is likely to become an even more delicate balance than exists today because of the competitive environment and manpower policies being discussed as part of the health care reform debate. Proposed manpower policies are being designed to attract a greater number of health care providers to rural and inner-city underserved areas as well as to train a greater number of primary care or generalist physicians.

There are a number of proposals to limit the number of first-year residency positions available each year to 110 percent of the number of graduates of U.S. medical schools. Approximately 16,700 students graduate each year from U.S. medical schools. Currently,

there are roughly 23,000 first-year positions in U.S. residency programs. The proposal to cap residency positions at 110 percent would cut approximately 4600 (nearly 20 percent) first-year residency slots.

Moreover, the Administration's plan calls for a phase-in of a 55:45 ratio of generalists to specialists by the year 2003. The Clinton plan includes OB-GYN in the definition of a primary care physician. The current ratio is approximately 30:70. The limitation on first-year residency positions and the dramatic shift toward generalist training will have serious implications for the VA because of its involvement in graduate medical education. How will the VA compete for a decreasing number of nationally allocated residency and fellowship positions?

I believe the best answer for the VA and academic medical centers is to continue to join together in sponsoring residency training. Integrated programs allow for the necessary volume of patients and staff to ensure a quality program.

Integrated residency training could be developed further into integration of service delivery. A fully integrated program could require all patients of the various sponsored plans to move through the various facilities of each of the partners as specific services become necessary. VA and their partners in academic medical centers ought to consider opportunities to integrate patient care services in order to achieve greater economies of scale and achieve efficiencies.

The VAMC in Tampa, located next to USF, operates a large (70-bed), world-class VA Spinal Cord Injury Center (VASCI). The importance and excellence of the Tampa VASCI Center has been recognized and an expansion of its bed capacity is anticipated. Plans for the 100-bed service have been approved. We hope construction will begin in 1994. The VASCI catchment area comprises Florida (except for the area around Miami), south Georgia, Alabama, and Mississippi. Approximately 300 new patients are admitted annually and 380 patients are seen in the outpatient clinic. VASCI home care is totally integrated with the VASCI service. The entire continuum of clinical care is provided at the VASCI, including initial rehabilitation, sustaining care for all complications of SCI, and ten beds reserved for long-term care.

Plan participants beyond the VA should have access to this facility if space is available, with preference always awarded to veterans. Sharing this resource would make the VA an attractive competitor for patients and would make the VA an attractive partner for other provider groups. Similar scenarios exist for the VA in other specialized areas, such as geriatrics, mental health, and substance abuse. The importance of sharing is heightened by the cost and unpredictable need of these specialized services.

Other partners in the network have services to offer that would be valuable to the VA. For example, the VA does not currently have the capability to provide pediatric services and has deficits in providing for women's health needs. The Tampa General Hospital, a community hospital affiliated with the University of South Florida, has a strong program in maternal and child health. Rather than the VA building such services to accommodate the needs of an expanded patient base, veterans and VA patients could access these services in the community hospital. To maintain quality, regional partnerships will become increasingly important for health service providers.

For entities involved in teaching, partnerships are even more critical because new paradigms for manpower will require careful allocation of resources and residency positions. From a quality and cost efficiency standpoint, we should encourage providers to form local networks, especially where integrated residency programs exist. For example, the VA could become the primary site for urology and cardiology fellowships -- meaning all patients in the network would go to the VA for such services. As a compliment, the medical center hospital could become the primary site for the infectious disease and immunology fellowships, taking responsibility for consults with all patients, including veterans, who require those services.

Further, it is possible through various types of specialization that certain activities would be reduced, such as transplantation surgery. As a result, it may not be feasible for a specific VA medical center to continue to join its academic affiliate in supporting the related educational programs and infrastructure. That VA facility, in turn, would need to make determinations regarding alternative access to these capabilities and expertise.

Similarly, substantial change in the nature, scope, and orientation of the VA health care system could have dramatic consequences for academic medicine. The VA has been an

invaluable partner in the education of health professionals and the advancement of scientific knowledge. Under some options academic medicine may face the need to shift both training and faculty to alternative locations. Under other options academic medicine may be challenged to expand its involvement to serve larger and new populations. Changes in either direction will require both extensive local planning and provision for an orderly transition.

As a final note, I would like to return to the fourth mission of the VA, to serve as a back-up to DOD. With the down-sizing of DOD operations, an effective back-up system that is a true functional system becomes even more essential. This cannot be achieved with a collection of under-utilized, private facilities. Another element of concern is what special care may be needed in the future for the care for new veterans. We all hope there will be no new global conflicts with large numbers of casualties again. However, we must be prepared for such events, as well as smaller, and perhaps, different problems. Are we prepared to care for chemical, biological, and nuclear injuries? Who will do the research? Who will stand ready? The VA-medical school alliance, I believe, is the a keystone to this protective arch.

Ultimately, it is impossible to consider all of these elements independently. Just as the interplay between health care reform and the VA delivery system must be considered as part of a simultaneous equation, so must the impact of various options incorporate the implications for VA relationships with academic medicine. My colleagues and I in academic medicine are eager to participate in these deliberations with the VA, with a particular focus on planning at the local level. I believe by working together we can enhance the quality and cost-effectiveness of care for veterans and ensure that VA and academic medicine continue our long-standing synergistic relationship.

Thank you for the opportunity to share my views and those of the AAMC this morning. I will be happy to expand on my remarks or respond to questions.

STATEMENT

before the
Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Thursday, November 18, 1993
9:30 am

Role of the Department of Veterans Affairs In National Health Care Reform

Statement of
Thomas L. Garthwaite, MD, President
National Association of VA Chiefs of Staff

NAVACOS
National Association of VA Chiefs of Staff

Mr. Chairman and Members of the Committee:

It is a privilege to represent the National Association of VA Chiefs of Staff and to address this Committee on the role of VA in national health care reform. Both the President's Health Security Act and various state health care initiatives are moving forward. We believe that the proposed role for the VA health care system is reasonable and offers us an exciting opportunity. We believe VA can perform well under these plans based on our experience in providing comprehensive care within a global budget. However, there are issues which will need to be addressed immediately for VA to succeed.

Our first concern is that some VA medical centers may start the competitive race behind other providers. Individual states are moving quickly to institute their state health care reform plans. It is unknown how long it will take to pass the Clinton Health Care Security Act. It is important that local VA medical centers are allowed to function as accountable health plans in states already enrolling patients.

Our second concern is that we will need to be able to provide care for veterans' dependents since many veterans will want to enroll in a family plan. While we are extremely sensitive to the fact that we must not deny any veterans access to VA in order to care for dependents, we feel strongly that the inability to offer care for dependents will deter many veterans from choosing a VA plan.

Our third concern is that the proposed methodology to adjust payments to accountable health plans based on risk is not defined. Since a majority of the patients currently treated by VA are high risk, the methodology for risk-adjusting payments will be critical if VA is to succeed. For example, risk adjustment based only on age and sex will not recognize the fact that veterans who receive their care from VA today are more likely than the general population to suffer from multiple chronic physical diseases, mental illness, HIV infection, and poverty.

Our fourth concern is that many of our medical centers have old physical plants which were designed for inpatient care. Many medical centers also lack amenities such as private bathrooms, private rooms, and bedside telephones. Price and competition should eventually allow patients to determine the market value of such amenities. Prior to equalization by market forces, VA medical centers will operate with a significant handicap.

Our fifth and perhaps most critical concern is the need to reinvent VA. A radical and profound change will be needed for VA to succeed under health care reform. The proposed reorganization of VA regions into smaller veteran service areas may be a positive step, but we are talking about a more fundamental change. The culture of VA must change. The current culture in the VA system is one which inhibits risk taking, encourages excessive paperwork, restricts flexibility, and tries to fix defects by inspection.

To succeed, we must have local autonomy to negotiate with the health alliances and to adapt to local market pressures. Marketing of our products

via advertising and word of mouth will be vital. We will not survive if we must continue to endure an army of inspectors whose main purpose is to find sporadic defects while ignoring abundant accomplishments. We must be able to hire the employees we need when we need them without regard to floors and ceilings. We must be able to buy equipment when it is needed rather than overworking our fiscal and acquisition specialists every September. We must be able to provide incentives to employees for exceptional quality and productivity. We must cease our practice of writing rules and regulations which inhibit change; rather, we must facilitate the implementation of new and improved processes.

Whether such fundamental change can occur within the current structure is not known. We are discouraged by our inability to make even small changes in medical center missions. There may be advantages to making the Veterans Health Administration a quasi-governmental organization like the Postal Service. We are encouraged by the direction provided recently by the Secretary and Acting Under Secretary for Health. We are also encouraged by the Vice President's initiative to reinvent government.

Recent studies indicate that VA provides health care with equivalent outcomes to the private sector at a lower cost. We believe we can continue to provide cost effective, high quality care and attract veterans who have a choice under health care reform. If we are to compete successfully, we will need your support and your trust.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
NOVEMBER 18, 1993

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to offer its views on the Department of Veterans Affairs' role as a participant in health care reform. In particular, we are glad to offer our analysis of the historic draft bill, the Health Security Act, with specific regard to Title VIII, Subtitle B - eligibility and benefits through the VA medical system. A thorough review of the VA medical care system's readiness to compete within the public health care sector is essential. As we proceed toward implementation of national health care reform, The American Legion will closely monitor the progress VA is making toward the goal of reform. There is much to be accomplished prior to the projected January 1, 1998, implementation of health care reform.

Mr. Chairman, for too long the Veterans Health Administration (VHA), has experienced severe staffing shortages, space deficiencies, equipment backlogs, and increasing workload restraints, mostly due to budgetary issues. Over the past decade, VA's ability to provide quality, timely health care has been strained to its maximum capability. The American Legion has repeatedly testified before Congress in defense of an adequate and rational approach to funding VA health care. Fortunately, the ills of the VA health care system are not beyond repair. We are thankful that the President's health care reform proposal will provide VA with the opportunity to improve its services. With proper guidance, steadfastness, determination and support, we believe VHA has a good chance to excel in the provision of quality medical care to veterans.

The Legion has previously testified that the primary foundations upon which VA must establish its posture among other health care providers are accessibility to care, promptness of service, and quality of care. **An American Legion Proposal To Improve Veterans Health Care,** published in January 1993, identifies the need for change in VA, and articulates our organization's proposals on the future structure of veterans health care. A comparison of the President's proposal to The American Legion's principles and recommendations for health care reform shows that many of these recommendations are met by the Administration's plan. In the course of this testimony, we will elaborate on the Administration's plan and point out those areas that cause us concern and require further clarification.

Mr. Chairman, VA will have approximately four years to prepare for the implementation of national health care reform. It is difficult to comment on all phases of this process, as we do not know the precise strategy of VA's implementation plan. We do know that VA must receive significant resource support prior to implementation in order to improve its current deficiencies. VA must develop an added presence in the community, to improve access to care. Ambulatory services must be provided on equal terms with the private sector. The current staffing and funding shortages must be alleviated so that VA can compete on a level playing field. All of these points must be addressed and corrected prior to implementation of health care reform.

It appears that VA has begun to plan in earnest for implementing the President's health reform plan. We hope the Congressional Veterans Affairs Committees will hold hearings periodically to assess the progress being made toward implementation of health care reform. Additionally, we are concerned about the absence of a concurrent eligibility reform proposal for VA health care. Prior to implementation of national health care reform, many more deserving veterans will continue to be denied access to VA

health care, for purely budgetary reasons. Where necessary, the VA health care system must be continuously strengthened. We do not want to see the current system regress as all eyes are focused on future reform.

SUMMARY OF THE HEALTH SECURITY ACT

Title VIII, Subtitle B, of the Health Security Act, proposes to amend title 38, United States Code, by adding Chapter 18 - Eligibility and Benefits Under the Health Security Act. Chapter 18 addresses the subjects of benefits, eligibility, and financial matters through the Department of Veterans Affairs medical system.

Subchapter II - Enrollment

The plan proposes that each eligible veteran who is entitled to the comprehensive benefit package under the Health Security Act, may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the Department shall enroll with a VA health plan. All CHAMPVA eligible individuals who are eligible for the comprehensive benefit under the Health Security Act may enroll under that Act with a VA health plan in the same manner as a veteran.

The Secretary may authorize a VA health plan to enroll members of the family of an enrollee, subject to payment of premiums, deductibles, copayments, and coinsurance as required under the Health Security Act. An enrollee's family includes (a) the individual's spouse if the spouse is an eligible individual; and (b) the individual's children (and, if applicable, the children of the individual's spouse) if they are eligible individuals.

Subchapter III - Benefits

The Secretary shall provide to each veteran eligible under the Health Security Act, the care and services that are authorized to be provided under chapter 17 of title 38,

United States Code, in accordance with the terms and conditions applicable to that care, notwithstanding that such care and services are not included in the comprehensive benefit package.

The following veterans are eligible for additional care and services, not included in the comprehensive benefit package:

(1) Any veteran with a service-connected disability.

(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

(3) Any veteran who is in receipt of, or who, but for the restrictions set forth in section 1151 of title 38, USC, would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement.

(4) Any veteran who is a former prisoner of war.

(5) Any veteran of the Mexican border period or World War I.

(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of chapter 17 of title 38, USC.

In the case of a veteran who is eligible to receive care or services under section 1710(a)(1)(G) of title 38, USC, for a disability which may be associated with exposure to a toxic substance, radiation, or environmental hazard, the Secretary shall furnish such care or services to that veteran if: (1) The veteran is eligible for care and services whether or not such veteran is a VA enrollee; and (2) the veteran shall not be subject to any charge or any other cost for such care and services.

The Health Security Act proposes that in order to meet the special needs of veterans, the Secretary may offer to veterans supplemental health benefits packages for health care services not included in the comprehensive benefit package. The supplemental health benefits package offered

may consist of any or all of the benefits that the Secretary may provide under chapter 17 of title 38, USC. The supplemental benefits package would be available to veterans not entitled to such services under the Health Security Act. The Secretary shall charge a premium for a supplemental health benefits package, and the amount of such premium shall be established so as to cover the actual and full costs of care. A VA health plan may offer supplemental health benefits policies for health care services not provided under chapter 17 of title 38, USC, and cost sharing policies consistent with the requirements of subtitle E of title I of the Health Security Act.

The Act proposes that a veteran who is residing in a regional alliance area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by VA, may be provided the items and services in the comprehensive benefit package by a VA health plan only if the plan is reimbursed for the actual and full cost of care.

Subchapter IV - Financial Matters

In the case of a veteran who is entitled to basic and supplemental benefits under the Health Security Act and enrolled in a VA health alliance, the Secretary may not impose or collect from the veteran a cost-share charge of any kind. For other enrollees, the Secretary shall charge premiums and establish copayments, deductibles, and coinsurance amounts. The premium rate, and the rates for deductibles and copayments, for each VA health plan shall be established by that health plan based on rules established by the health alliance under which it is operating.

Under Medicare coverage and reimbursement, the Health Security Act proposes that a VA health plan or Department facility shall be deemed to be a Medicare provider under title XVIII of the Social Security Act on or after January 1, 1998. Further, the Secretary of Health and Human

Services shall enter into an agreement with a VA health plan or Department health-care facility to treat such plan or facility as a Medicare HMO, under section 1876 of the Social Security Act, in any case in which that health plan or facility seeks to enter into such an agreement. In the case of care provided to a veteran, other than a veteran entitled to receive the comprehensive benefit package or the supplemental benefit package, who is eligible for benefits under the Medicare program, The Secretary of Health and Human Services shall reimburse a VA health plan or Department health-care facility providing services as a Medicare provider or Medicare HMO on the same basis as other Medicare providers or Medicare HMOs, respectively. Under this section, the Secretary of VA shall require the veteran to pay to the Department any applicable deductible or copayment that is not covered by Medicare.

The Secretary of VA has the right to recover or collect charges for care or services provided to an individual through a VA health plan who has coverage under a supplemental health insurance policy pursuant to part 2 of subtitle E of title I of the Health Security Act or under any other provision of law, or who has coverage under a Medicare supplemental health insurance plan, <u>but not including care or services for a service-connected disability.</u>

The Secretary of VA shall establish for each VA health plan a separate revolving fund to which all amounts received by the Department by reason of the furnishing of health care by a VA health plan or the enrollment of an individual with a VA health plan shall be credited to the revolving fund of that health plan. A VA health plan may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of such care have been covered by appropriations. Such amounts shall be deposited in the General Fund of the Treasury. Each revolving fund for a health plan shall be managed by that health plan, and

amounts in a revolving fund for a health plan are to be made available for the expenses of the delivery of the items and services in the comprehensive benefit package by the health plan.

The provisions of this Act shall apply with respect to the furnishing of care and services by any facility of the Department that is not operating as or within a health plan certified as a health plan under the Health Security Act; and to veterans not eligible to enroll in certified VA health plans.

Subchapter V - Participation as Part of National Health Care Reform

The Secretary of VA shall organize health plans and operate Department facilities as or within health plans under the Health Security Act. The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as or within health plans operating under the Health Security Act.

A State (or a State-established entity), (1) may not impose any standard or requirement on a VA health plan that is inconsistent with this Act or any regulation prescribed under this section or other Federal laws regarding the operation of the Act; and (2) may not deny certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State or health alliance.

The Secretary may enter into a contract for the provision of services by a VA health plan in any case in which the Secretary determines that such contracting is more cost-effective than providing such services directly through Department facilities or when such contracting is necessary because of geographic inaccessibility. The Secretary may also enter into agreements with other health plans, with health care providers, and with other health industry organizations, and with individuals, for the sharing of

resources of the Department through facilities of the Department operating as or within health plans.

In order to carry out the provisions of the Health Security Act, the Secretary may conduct administrative reorganizations of the Department and enter into contracts for the performance of services previously performed by employees of the Department. The Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans under the Health Security Act. The Secretary may conduct appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans. Such activities may only be carried out using nonappropriated funds.

The Secretary may apply for and accept any grant or other source of funding that is intended to meet the needs of special populations that is currently unavailable to facilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.

AMERICAN LEGION ANALYSIS OF THE HEALTH SECURITY ACT

Mr. Chairman, The American Legion appreciates the fact that the president's health plan would give VA hospitals an opportunity to compete within the marketplace and continue to serve America's veterans. The plan contains many favorable features for the veteran community. Some features of the plan embrace proposals contained in the document, **An American Legion Proposal To Improve Veterans Health Care.** While we are glad to offer our comments on the Health Security Act, we hope that whatever the outcome of the President's proposal, the VA will move ahead with much needed reform.

Title VIII, Subtitle B of the Health Security Act - the Department of Veterans Affairs, provides the first real opportunity to deal effectively with the many shortcomings facing the VA medical system. President Clinton's health care reform effort will have a major impact on the way veterans receive health care, and on the way the Department delivers that care. The Legion will work toward the goals outlined for veterans in the administration's plan, and we hope to interact with VA in the planning for implementation of national health care reform.

Problems Confronting VA Health Care

The VA health care system today operates under specific Congressional mandates designating those veterans who shall receive certain medical services and those who may receive them. Health care services for mandatory and discretionary veterans are further defined by such factors as the level of disability for service-connected veterans and the income of nonservice-connected veterans. Even without national health care reform, VA's complex eligibility rules urgently require simplification.

The present VA system is funded entirely by federal appropriations intended to cover those veterans to whom certain services are guaranteed by law. VA has discretionary authority to provide certain services to other veterans within currently available resources on a facility-by-facility basis. This can and does result in curtailing service to some veterans, even those who may have been recent VA patients. Under present law VA may not retain the funds it collects by filing claims with private health insurance carriers covering the nonservice-connected conditions it treats. All insurance payments revert to the U.S. Treasury, except amounts sufficient to cover VA's claims processing costs. The law also prohibits VA from collecting payments from Medicare, even though veterans it treats may be covered by that program.

Other operational problems concern the lack of funds to provide adequate staffing for all mandated programs, the method of funding disbursement to individual medical facilities, the responsibility of providing quality health care services, the long-standing lack of emphasis on ambulatory care services, and the many inadequate physical facilities to provide efficient health care.

The VA System Under National Health Care Reform

The American Legion supports many proposals related to veterans health care under the Health Security Act. In particular, the following provisions recommended in the President's plan, are included in the Legion's proposal to improve veterans health care:

- VA remains an independent system committed to veterans health care.
- The new system will establish a VA Plan open to enrollment by all veterans.
- The VA Plan offers basic comprehensive benefits identical to those guaranteed to the general public by all other qualified plan providers.
- Veterans now in the mandatory category for VA care receive these benefits with no copayments or deductibles.
- Higher income veterans may select a VA Plan from among other locally available enrollment choices.
- Service-connected and low-income veterans continue to receive supplemental VA medical services for which they are now eligible.
- VA will be authorized to offer supplemental benefits to higher income veterans for an added premium.
- VA's resource base becomes a combination of federal appropriations and other revenues.
- Comprehensive and supplemental benefits for service-connected and low-income veterans are ensured by VA appropriations.

- VA receives health alliance payments, enrollee premiums, copays and deductibles and retains all third-party collections.

Added features of the proposal include:

- Restriction on receiving Medicare payments for enrolled higher-income veterans would be lifted.
- VA can borrow from a federal revolving fund to assist with health plan start-up costs.

Key features of the guaranteed benefit package include:

- Full coverage of care as a hospital inpatient including bed and board, professional services, laboratory, diagnostic and radiology services, and 24-hour emergency services.
- Guaranteed access to comprehensive outpatient services.
- Broad provision of clinical preventive services including immunizations, screenings, routine vision and hearing examinations.
- Unlimited outpatient prescription drugs and biologicals.
- Outpatient rehabilitation services.
- Durable medical equipment, prosthetic and orthotic devices.
- Mental health and substance abuse treatment.
- Hospice, home health and extended care services.
- Women veterans health related services.

Supplementary services that would continue for eligible veterans are:

- Long-term/nursing home care.
- Adult dental services.
- Treatment for post-traumatic stress disorder (PTSD).
- Expanded rehabilitation and prosthetic services.

- Residential programs in mental health and substance abuse.
- Eyeglasses and hearing aids.

Mr. Chairman, clearly the President's Health Care Reform Plan would improve the health care security of America's veterans. For many veterans, particularly the nonservice-connected, the services included in the guaranteed benefit package would exceed those that VA is now authorized to provide. Many of the provisions recommended in the Legion's proposal to improve veterans health care are included in the Administration's plan. The Legion supports the proposal that a VA health plan shall be considered eligible to receive payments for coverage of services furnished to Medicare beneficiaries under title XVIII of the Social Security Act.

Some states are moving ahead of the Federal effort for health care reform. In these states, VA must have the authority to serve veterans, equal to other health care providers, under the terms and conditions determined by the state. The Legion believes that as appropriate, all provisions in the Health Security Act regarding veterans health care, should apply to VA in any state, in advance of the general implementation of national health care reform.

The VA and Department of Defense (DoD) conduct a number of health care sharing agreements. How VA/DoD sharing programs will be conducted under health care reform is unclear. Another significant concern is the matter of self-employed service-connected veterans who, under the President's plan, will be required to pay the 80 percent employer's contribution for their own health care coverage. The Legion believes these individuals should be entitled to claim a 100 percent income tax deduction if they enroll in the VA health alliance or be exempt from paying the employer's contribution.

Another concern involves eligible veterans' dependents. Veterans eligible to enroll in a VA health alliance, could be discouraged from doing so due to separating their coverage from their dependents coverage. The effect of this possibility suggests that VA should consider opening up the VA health alliance to veterans' dependents with the assurance that every eligible veteran enrollee will have had the opportunity to afford themselves of the benefits package offered by VA. There are obvious strengths and concerns to both sides of this subject. However, given the time that VA will have to work out the details of the program's implementation, this matter deserves serious consideration.

The American Legion believes that a veteran who suffers a catastrophic illness or injury, payment for which would render him/her destitute, or any veterans proven to be uninsurable, should receive care from VA without charge. We support the proposal for contracting authority by a VA health plan where such authority is more cost-effective than providing health care services directly through the Department or when such contracting is necessary because of geographic inaccessibility. This authority should improve veterans and dependents access to VA health care. We also support resource sharing between VA and other private sector health plans or health care providers, or individuals.

Mr. Chairman, the matter of VA receiving adequate appropriations to upgrade its facilities and staffing levels is crucial to allowing VA medical facilities to compete with other state health alliances, under the Health Security Act. Each year, prior to the full implementation of national health care reform, VA will require new resources to improve its physical plants, begin new clinical initiatives, particularly community-based ambulatory care clinic programs, and generally prepare for the full-scale implementation of health care reform. The American Legion believes the most ill-advised plan will be for the Office of

Management and Budget (OMB), to reduce direct health care and related VA appropriations, to offset the added revenues proposed in the President's health care plan. VA will always require certain direct appropriations for the care and treatment of service-connected and low-income veterans, and funding to support the system's infrastructure. The Legion recommends that discussions are held on how the projected revenue increases will be applied and utilized by VA. Third-party reimbursement, particularly Medicare, has nothing to do with "making money"; it has everything to do with equitable remuneration for services rendered and the survival of VA. Consequently, to successfully carry-out health care reform in VA, it is essential for planning purposes to accurately project what the Department's health care budget will be from year to year. The goal of VA's effort is to improve its ability to conduct its mission and to compete within a reformed marketplace.

Mr. Chairman, the VA health care system as we know it today, will be significantly strengthened under National Health Care Reform. The VA system can be a national model for successfully integrating outpatient, acute hospital and long-term services. VA's global budget management experience will promote efficiency and economy. A fiscally sound system ensures that VA can continue its support of research in basic science, clinical applications and health systems. VA must remain attractive for medical school affiliations and in the training and education of health care professionals. National Health Care Reform brings with it the hope that VA can begin to confront its myriad funding and access deficiencies, and strengthen the quality of care provided. The goal of The American Legion is that VA will ultimately become a key component of national health care reform, and retain its central commitment to America's veterans.

Mr. Chairman, that concludes our statement.

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

HEALTH CARE REFORM AND THE ROLE OF VA

WASHINGTON, D.C. NOVEMBER 18, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States I wish to thank you for inviting us to participate in today's most important hearing. Through the years the VA health care system has been of profound importance to veterans throughout the nation. In carrying out this nation's obligation to care for her military veterans in their time of need, the VA health care system has also proven to be of great service to all veterans. VA contributions in the areas of medical research and education have been instrumental in making overall American health care and science the best in the world. Further, in caring for medically indigent veterans in a highly cost effective manner, VA has reduced the burden which would have been placed on Medicaid as well as other federally funded social services. The savings accrue to benefit the American taxpayer. In our view, there can be no doubt that the VA health care system should be a critical and integral part of any national health care delivery system. The VFW is highly gratified in being provided this opportunity to help to more precisely delineate the role of the VA health care system in this regard.

As we are all aware, President Clinton has revisited and revamped his national health care plan which he presented to the Congress and the American people on October 27th. In the face of waning public support the President held an unusual televised "relaunching" session in the Capitol's historic Statuary Hall. While asserting that the nation is "choking on a health care system that is not working," the President also indicated that he

and the First Lady would remain flexible with respect to the broad elements of the plan.

While the VFW certainly has no objection to reworking national health care with respect to financing, reducing some of the bureaucratic burden, and placing new limits on tax payer subsidies, we are adamant that the Administration hold fast with respect to its promise to assure that the VA health care system remains as an autonomous health care provider for America's veterans. I am taking this opportunity to provide you with some of the VFW's initial views regarding this enormous legislative undertaking.

The Veterans of Foreign Wars is committed to the premise that veterans, by virtue of the special service and sacrifice they have offered up on behalf of the national good, are entitled to special honor and recognition. The VA health care system--the world's largest integrated medical system--was created just for that purpose: to provide a special place where veterans exclusively would be provided treatment for their particular illnesses and injuries.

Over the years, the VFW has clearly and repeatedly articulated its objective that the VA health care system be maintained and enhanced so that all veterans who turn to VA will be provided the state of the art medical care that they need and have earned. In this regard, the VFW acknowledges that the Administration is putting forth a national health care plan which provides for the retention of VA as an independent health care provider for veterans, and even provides the potential for its becoming the health care provider of choice for all of America's veterans.

Within the framework of the health care reform, the VFW will labor tirelessly to ensure that veterans retain their unique status among the nation's health care recipients, continuing to receive tangible evidence that their commitment to the country is recognized and honored.

At this juncture the VFW is unable to give a final position on the Administration's proposal. Furthermore, we must all

remember that even if the health care plan appears perfect with respect to its treatment of America's veterans, Washington's special interests are already at work to alter it in their favor, which in turn could be to the detriment of veterans. With this in mind, none of us should think even for a moment that this enormous legislative package will make it off of Capitol Hill unscathed. Even so, the VFW has offered its support of the concept and a number of the package's features which affect the veteran community. Here follow a number of key VFW points that now appear to be incorporated into the Administration's health care reform package:

POINTS OF APPARENT AGREEMENT

Retention of the VA as an Independent and Autonomous Entity

Through the years VA has played a crucial role in the life of the nation: as back up to DOD in time of war; as a prominent educator of health professionals; as a national leader in medical areas of research such as PTSD, blind rehabilitation, and spinal cord disabilities; and most notably, as the primary care giver to the nation's veterans. In the VFW's view, VA's sheer size and numerous areas of scientific expertise alone mean that it should serve as the model and corner stone of any national health care plan. The VFW applauds the Administration's recognition of VA's significant contributions and import to the nation in its reform package.

Competition With Other Health Alliances

The VFW strongly believes that the quality of care provided at many VA medical centers is not only comparable to the private sector, but in many cases superior. Because of veterans' special needs, the system has been compelled to develop innovative and cost efficient ways of delivering care. Given the provision of an appropriate adjustment period and sufficient funding to better employ its resources, we believe VA will be well able to compete within a fair and equitable health care market. So long as VA is provided with the necessary funding and personnel to allow it to open itself up and care for the needs of all veterans, we believe the VA should be very successful in attracting veteran consumers of health care. We continue to urge the Admin-

istration and the Congress, however, not to forget the special needs and service of veterans, and the fact that VA will not be automatically transformed into the health care provider of choice for veterans--sufficient funding and other adjustments are absolutely essential for this to come about.

Enrollment for All Veterans in VA Health Plans

The Administration's plan, as we understand it, would provide unfettered access to all veterans to care at VA. This is in keeping with a long standing VFW objective.

ADDITIONAL VFW OBJECTIVES

Full Appropriation Support

The VFW is adamant that the U.S. government has the unconditional responsibility to care for those courageous men and women who have sacrificed their health and well being in the service of their country. Full federal funding of the post-reform VA health care system is therefore not only a moral imperative, but a patriotic responsibility. Both the Congress and the Administration must ensure that the annual appropriation, at a minimum, is sufficient to ensure the provision of a full continuum of care for all enrolled veterans.

Retention of Third-Party Payer and Medicare Receipts

In light of the fact that VA has been plagued by underfunding through the years, it is essential that VA be not only authorized to collect (as provided in the Administration's plan) but also retain all third-party and Medicare funds. It is only in this way that VA will be initially enabled to reconfigure its resources to provide a full continuum of care to all enrolled veterans and eventually become their health care provider of choice.

Assurance That No Veterans Will See a Reduction In His or Her Health Care Benefits

The VFW is adamant that veterans receive "special status" with respect to their health care benefits in recognition of their service. This means that not a single veteran should see a reduction in health care benefits as the national health care plan is developed and implemented.

PRELIMINARY CONCERNS

The VFW also has some strong preliminary concerns with respect to the Administration's national health care reform package as we currently understand it. They are as follows:

Opening the VA to Dependents at Discretion of the Secretary

Throughout its history the VFW has adamantly opposed the admission of non-veterans into the VA until such time as all veterans are able to obtain VA medial care. We understand the need to be "family friendly" if VA is to successfully compete within the context of the Administration's market based health care reform plan. This is why the reform plan would give the Secretary the authority to treat veterans' dependents. Even so, we oppose the admission of non-veterans until all veterans are assured a full continuum of health care.

Retention of Third-Party Payer/Insurance and Medicare Payments

The VFW views this as critical in providing VA with sufficient funding to modernize and reconfigure its services so that it may become the primary health care provider for all of America's veterans. We are insistent that these third-party collections not be offset from the VA's annual appropriation and that Congress and the Administration establish an appropriation "floor" in order to guarantee sufficient dollars to ensure the financial viability of the system as it moves into the 21st Century.

The VFW is also adamant that the retention of these monies by VA for service-connected care not transfer the government's responsibility for its service-connected veterans over to third-party payers in the private sector. Absolving employers of the health care reform plan would address this issue and promote veterans hiring practices as well.

Eligibility Reform

The VFW makes mention of the fact that while the Administration's plan does provide access to all veterans through open enrollment criteria for VA health care, it does not satisfy our requirements for eligibility reform. The foremost VFW requirement is to: enable VA to provide all veterans with a full continuum of care (from preventive to long term care) regardless of

degree of service-connected disability or ability to pay or other currently divisive criteria.

SUMMARY

The VFW will continue to assert itself in working on behalf of legislation which will render VA the most attractive health care option of America's veterans. Given the provision of sufficient funding coupled with bold and innovative leadership from the Congress and VA officials, the VA medical system will be transformed for the better and veterans will select it as their health care provider within the framework of national health care reform. The VFW remains committed to the proposition that veterans are deserving of special status by virtue of their service and we will strongly support initiatives that lend substance to that claim. Health reform is critical and we believe veterans must play an important role if it is to be realized. Mr. Chairman, this concludes my statement. Germane VFW Resolutions are appended for your review. I would be happy to respond to any question you may have.

Resolution No. 603

AUTHORIZE RETENTION OF THIRD-PARTY AND MEDICARE REIMBURSEMENTS BY VA

WHEREAS, by law the Department of Veterans Affairs is mandated to provide high quality medical care to all eligible veterans by reason of their service to the nation; and

WHEREAS, it has been affirmed that the Department of Veterans Affairs is now drastically underfunded and unable to provide either the quality or the quantity of health care intended by the Congress and a grateful nation; and

WHEREAS, the VA health care system is required by law to collect payments from a third-party health insurer when certain insured veterans receive health care from VA; and

WHEREAS, such collections, other than for administrative costs, do not remain within the Department of Veterans Affairs and are instead deposited into the General Treasury Fund to achieve deficit reduction; and

WHEREAS, the Veterans of Foreign Wars holds that such third-party collections should remain with the Department of Veterans Affairs so that they might contribute toward improving the veterans health care service; and

WHEREAS, veterans receiving part A and B of Medicare are prohibited from selecting the VA medical system as their provider of choice because the Social Security Administration is prohibited under law from paying the Department of Veterans Affairs for such care as a third-party claim; and

WHEREAS, there are many outstanding VA health care facilities throughout the United States which are in desperate need of additional funds; now, therefore

BE IT RESOLVED, by the 94th National Convention of the Veterans of Foreign Wars of the United States, that we urge Congress and the Administration to take appropriate action to ensure that third-party collections by VA remain with the Department of Veterans Affairs and not be offset from its annual appropriation; and

BE IT FURTHER RESOLVED, that the Veterans of Foreign Wars supports Medicare reimbursement to VA for care provided to veterans without any offset from its appropriated funds.

Adopted by the 94th National Convention of the Veterans of Foreign Wars of the United States, held in Dallas, Texas, August 20-27, 1993.

Resolution No. 603

Resolution No. 608

FULL APPROPRIATION SUPPORT FOR VA MEDICAL CARE

WHEREAS, a succession of laws enacted by the Congress have stipulated specific types and levels of medical care for certain classes of veterans; for example, those who are service connected; and

WHEREAS, there is no binding language placing the government in the position of obligor in terms of precise levels of funding for this medical care that it directs to be provided; and

WHEREAS, this circumstance places the Department of Veterans Affairs, as the agent for the veterans it serves, in the position of perpetual supplicant in the matter of obtaining funds to carry out its moral and statutory mandates; and

WHEREAS, this situation impacts adversely upon veterans seeking medical care under programs established by the Congress; now, therefore

BE IT RESOLVED, by the 94th National Convention of the Veterans of Foreign Wars of the United States, that the obligation and requirement to adequately fund veterans health care shall be acknowledged and properly met through appropriations actions which provide requisite funding to support all veterans medical services and programs authorized by the Congress.

Adopted by the 94th National Convention of the Veterans of Foreign Wars of the United States, held in Dallas, Texas, August 20-27, 1993.

Resolution No. 608

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE
NOVEMBER 18, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, may I say how genuinely appreciative we are of the opportunity to appear before the Subcommittee today and relate the views of the DAV regarding the Department of Veterans' Affairs (VA's) role in the context of the President's proposal for National Health Care Reform.

Mr. Chairman, much has been said and discussed regarding the VA Health Care System over the preceeding years. More recently, your Subcommittee has had a number of hearings regarding the VA health care system in general, and the VA's role in a reformed health care system. Likewise, a number of hearings conducted by Congressman Lane Evans, Chairman, of the Subcommittee on Oversight and Investigations has spanned a broad spectrum of the VA health care delivery system in recent months. Also, under the Chairmanship of Senator Rockefeller, the Senate Veterans' Affairs Committee has, this session of Congress, conducted a series of hearings regarding VA's role in a reformed health care delivery system.

Mr. Chairman, the combined efforts of the House and Senate Veterans' Affairs Committees in the recent past have, in our view, set the stage for today's hearing.

Mr. Chairman, for the purposes of discussion, our testimony today will be directed at the President's health care reform package released on October 27, 1993 known as the "Health Security Act." Specifically, we will address Subtitle B, Department of Veterans' Affairs, of Title VIII - Health and Health Related Programs of the Federal Government. We realize, in all probability, the text of this document is subject to change upon formal introduction of legislation encompassing the President's reform proposal. However, the working document serves as an excellent focal point for discussion as we believe it represents, conceptually, the necessary ingredients for reform of the VA health care delivery system while, at the same time, allows VA to position itself for the transition into a quality, viable health care delivery system for the future.

Section 1811 extends, to each and every veteran the option to enroll in the health care plan of their choice. If the veteran desires to receive care through VA in terms of receiving the comprehensive benefit package, such a veteran would be required to enroll with a VA health plan.

Section 1812 extends the same choice offered to veterans to those individuals eligible for CHAMPVA benefits. Those individuals so eligible may enroll with a VA health plan in the same manner as a veteran.

Section 1813 grants the Secretary of the VA the authority to enroll family members of a veteran enrollee in a VA health plan, subject to full payment of premiums, deductibles, copayments, and coinsurance as required under the Act.

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Mr. Chairman, we support the intent of Section 1813 that would grant discretionary authority for family members to be a part of the VA health plan. We do not, however, at this time envision the Secretary authorizing the actual treatment of family members within a VA facility. Rather, in those instances where a veteran's choice is for family members to receive their care through VA, we understand that such care would be "managed" and paid for by VA but provided by non-VA sources.

Section 1821 mandates that the Secretary ensures each established VA health plan provides to each veteran enrolled the items and services that are provided in the comprehensive benefit package offered to all citizens.

Section 1822 mandates that certain medical care and services now provided to certain veterans under Chapter 17, Title 38, be continued to be provided, notwithstanding such care and services are not included in the comprehensive benefit package.

Mr. Chairman, we interpret Section 1822 to ensure that veterans now entitled to certain care and services based on current eligibility criteria, will not be denied such care and services under the reform proposal. For example, service-connected disabled veterans rated 100 percent permanently and totally disabled and now entitled to dental care would not lose that eligibility, notwithstanding that dental care is not a part of the comprehensive benefit package.

Section 1823(a) identifies the group of "core-entitled veterans" eligible for additional care and services as described in Section 1822. They are any veteran:

* with a service-connected disability;

* whose discharge or release from active military service was for a disability incurred or aggravated in a line of duty;

* in receipt of, or who, but for suspension pursuant to Section 1151, Title 38, would be entitled to disability compensation;

* who is a former prisoner of war;

* of the Mexican Border Period of World War I; and

* who is unable to defray the expenses of necessary care as determined under Section 1722(a) of Title 38.

Subsection (b) requires VA to furnish care and services to veterans who were exposed to a toxic substance, radiation or other environmental hazard.

Subsection (c) requires VA to furnish such care whether or not the veteran is a VA enrollee and precludes any charge or other cost to be incurred by the veteran for such care and services.

Section 1824 authorizes the Secretary to offer certain higher income veterans, certain supplemental health benefits packages for health care services not included in the comprehensive benefit package. Premiums would be charged for such benefits sufficient to cover the actual and full cost of the care provided.

Such premiums would not apply to the "core-entitled veteran" eligible for the supplemental services.

Section 1825 authorizes the VA to provide services, defined in the comprehensive benefit package, to a veteran enrolled in a plan other than a VA plan only if VA is reimbursed the actual and full cost of care provided.

Subchapter IV - Financial Matters

Section 1831 precludes the Secretary from imposing or collecting from a core-entitled veteran, described in Section 1823(a) a cost-share charge of any kind. For other VA enrollees, the Secretary would be required to charge premiums and establish copayments, deductibles and coinsurance amounts based on rules established by the health alliance under which the VA plan operates.

Section 1832 requires that a VA health plan or Department facility shall be deemed to be a Medicare provider. Also, the Secretary of Health and Human Services would be required to enter into an agreement with a VA health plan and treat such a plan or VA facility as a Medicare HMO if VA seeks to enter into such an agreement. Additionally, it would be required that VA be reimbursed for care provided to any veteran, other than a core-entitled veteran, on the same basis as Medicare reimburses other Medicare providers. Those veterans whose care is reimbursed by Medicare will be required to pay to VA any applicable deductible or copayments not covered by Medicare.

Section 1833 grants VA the right to recover or collect charges for care or services provided by VA to any individual who has coverage under a supplemental health insurance policy (as defined by the Health Security Act) or coverage under a Medicare supplemental health insurance plan. The exception would be for care or services received for a service-connected disability where such recovery would not occur.

Section 1834 requires the Secretary to establish a separate revolving fund for each VA health plan. Any funds received by VA by reason of the furnishing of health care by a VA health plan shall be credited to the revolving fund of that plan. The exception being VA may not retain amounts received for care furnished "to a VA enrollee in a case in which the costs of such care have been covered by appropriations." Also, each revolving fund for a health plan shall be managed by that health plan and the amounts in the revolving fund would be available for the expenses of the delivery of services in the comprehensive benefit package.

Mr. Chairman, in our view, the statutory language regarding the VA's ability to collect and retain funds -- other than appropriated funds -- requires clarification, strengthening and additional definition.

Mr. Chairman, it has long been the position of the DAV, and I venture to state other Veterans Service Organizations, that any proposal reconfiguring the VA health care delivery system would, as a necessity, require additional sources of revenue outside of the traditional appropriation process. However, to extend such authority to VA should not, in our view, automatically translate into appropriated funds being reduced dollar per dollar from those generated from outside sources. Rather, we envision the federal government's responsibility to continue to be to provide for the care of the service-connected, as well as the lower income veteran. The DAV does not envision nor support collection of funds from third-party payors for the treatment of service-connected disabilities.

However, in addition to appropriated funds, VA must be permitted to collect and retain, without corresponding offsets, reimbursement for the provision of care to certain veterans.

Only in this manner can VA expect to be able to upgrade their system and remain viable into the future.

Organization of Department of Veterans' Affairs Facilities as Health Plans

Mr. Chairman, Section 8102 of the Act proposes to create, in Chapter 73, Title 38, a new Subchapter IV, "Participation as Part of National Health Care Reform," that would enable VA to organize itself in a manner that would allow VA to operate as a competitive health care delivery entity.

Section 7341 of the new Subchapter would require the Secretary to organize health plans and operate department facilities as or within health plans under the Health Security Act. The Secretary would prescribe regulations establishing standards for VA in which to operate. Within certain geographic areas, VA would be authorized to organize as a single health plan encompassing all department facilities or may operate as several health plans. Also, and importantly, no State may impose any standard or requirement on a VA health plan that is inconsistent with Title 38 and may not deny certification of a VA health plan on the basis of a conflict between a rule of a State or health alliance and Title 38.

Section 7342 authorizes VA to enter into contracts for the provision of services when it is determined contracting is more cost effective than providing such services directly through VA facilities or because of geographic inaccessibility.

Section 7343 grants the Secretary authority to enter into agreements with other health care plans for the sharing of VA resources through VA facilities.

Section 7344 grants the Secretary flexibility in certain administrative and personnel areas concerning administrative reorganizations, contract agreements, and permits VA to carry out appropriate promotional, advertising and marketing activities with the use of non-appropriated funds.

Finally, Section 7345 grants the Secretary the authority to apply for and accept any grant or other source of funding intended to meet the needs of special populations that would otherwise be unavailable to VA.

Mr. Chairman, overall, the DAV is generally supportive of the role as identified for the VA in the President's health care reform proposal. As indicated, we are concerned about the viability of the funding process and are confident it can be worked out to everyone's satisfaction.

Also, we view as critical the need to treat VA health care as an entitlement to those veterans defined in Section 1823(a). Entitlement to VA care is a necessary ingredient toward the successful transition into national health care reform and serves as a guarantee that veterans will be able to access the VA and avail themselves of a full continuum of care and necessary medical services.

It is our belief that VA is extremely well positioned to enter an era of health care reform in a manner that will match or exceed the expectations of those who ardently believe health care reform is vital to the nation. The VA possesses the facilities, physical plant, personnel and patient mix to make this happen. Additionally, the level of expertise and potential expertise VA possesses in the treatment of veterans for a full continuum of care is unmatched, as a system anywhere in the world. The potential for VA to "hit the ground running" is extraordinary.

The DAV certainly agrees that the process of change in a system such as VA's is a monumental undertaking. Health care reform will be a monumental perhaps decade long process. VA is not spared from such a process. There is a great and compelling need for the VA to utilize the best minds of the system in order to come up with policies, procedures and innovative methods to launch the VA into health care reform and keep it on a steady, focused course.

However, the DAV is fearful that if changes are not made immediately, then the window of opportunity will be slammed shut and lost. If VA cannot make changes today they may not have the opportunity to make them later.

For example, VA clinics need to be open and available to veterans when needed. If VA is to be an attractive health care provider, they must extend their hours of operation into the evenings and on the weekends so veterans who so choose can avail themselves of treatment. By this we do not suggest skeleton crews would staff the clinics but, staffing would be adequate to meet the actual and projected workloads.

In the same vein, VA needs to move now into the era of community based health care clinics. These need not necessarily be fully and expensively equipped facilities but rather exist at a location convenient to where veterans reside so they can, when needed, use VA in an easily accessible manner.

From a pragmatic view point, the components that form VA's strengths also cause issues to exist that present very real obstacles to VA that, if not overcome, may effectively preclude them from succeeding in an era of health care reform.

The salient point we wish to stress today is the absolute critical need for VA to do something immediately. The issues have been identified and discussed by all who have an interest in VA health care. However, not much in the way of change has been seen as of yet.

It does little good to continue to discuss issues that need not discussion but require action. Seemingly, there is an inbred resistance to change. The traditional manner in which health care has been practiced in VA causes resistance to change. It is this mindset that must be addressed and altered.

Mr. Chairman, our testimony is not intended to imply that it is only VA being referred to. Indeed, just the opposite is the case. Many other entities have vested interests in VA and play a part, however well intentioned in VA's inability to change.

The VA does not necessarily need additional task forces to be formed to determine what needs to be done. What is needed is definitive action. It escapes us why, when one VA facility institutes a program that produces positive changes for veterans, such a program cannot be replicated by some or all other VA facilities.

The VA is a good system, Mr. Chairman, one we all seem to agree deserves to be given the opportunity to remain. The President's health care reform proposal gives VA that chance. We, as believers in the virtues of the system, must now make the commitment toward preserving the system. To do so necessarily entails change.

Change that will be good for veterans must be the cornerstone of the VA. It is long past time to consider any parochial issues that often equate to what is good only for the system.

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Mr. Chairman, this concludes my testimony, and I would be pleased to respond to any questions you may have.

SERVING
WITH
PRIDE

Testimony of

MICHAEL F. BRINCK

AMVETS
National Legislative Director

before the

House Veterans Affairs Subcommittee
on
Hospitals and Health Care

concerning the

Health Security Act

November 18, 1993

AMVETS

Mr. Chairman, AMVETS would like to thank you for holding this hearing. Now that the president has delivered his bill, it is time to move forward with reshaping VA medical care.

There is one overriding principle that we should keep in mind as we proceed together towards reform; VA medical care cannot go on organized, managed and delivered in its current form. If the system is left unchanged -- and the members of this committee are part of that system -- it will surely die. VA medical care will go from a highly diverse, full spectrum health care provider, a respected research organization and national emergency backup to an old soldier's home , at best. We will have squandered a national asset.

AMVETS would like to make several observations before we address the provisions of the Health Security Act.

First, it is well past time to undertake reform. The veterans organizations here today have been testifying for years about the need to do business differently. It is encouraging to see that the president's plan incorporates many of the ideas we have espoused.

Fortunately, many states are ready to start reform very soon, and we want to state that we support implementing pilot programs in some or all of those states that will allow VA to test new delivery models as well as eligibility reform. Pilot programs will let VA learn how to do it right and more importantly, how not to do it. Will there be mistakes? Most likely. But the bigger mistake would be to force VA to not participate in local reform thereby losing any chance of retaining the loyalty of the veterans in the area as well as garnering any additional potential market share.

Pilot programs will not be painless. Many VA medical centers serve populations from several states and until all surrounding states have put health alliances (funding mechanisms) in place, it appears VA will be reimbursed for the standard package only for those veterans living in the state with the health alliance. Will veterans from surrounding jurisdictions also be treated under the new rules? Will there be two levels of care -- one for veterans residing within the

health alliance and one for those residing outside the alliance?

This brings about our second concern -- funding -- especially appropriated funding. AMVETS recognizes that VA will have to compete for non-appropriated funding streams. But they must not be punished for being successful. We are already hearing rumors that the Office of Management and the Budget intends to reduce significantly the appropriation for the VA medical system. Since the system now treats very few discretionary care veterans, it is hard to imagine what kind of twisted logic arrives at any such decision. The federal government must not abandon its financial and moral responsibility for the most deserving of our veterans -- the service-connected and those who are medically indigent. We call on Congress to devise a funding formula based on core veteran capitation that will ensure VA managers of a dependable funding base.

Third, the issue of treating of non-veterans in VA facilities must be addressed. It has long been AMVETS position that we would be willing to discuss such treatment only when all veterans had been accommodated within the VA system. It now appears that VA has moved to provide access to all veterans in one form or another, and it is now time to begin the dialogue on the extent to which the VA system and veterans might benefit from treating non-veterans.

Non-veterans can be loosely lumped into several categories: dependents of veterans, the dependents of those now on active duty, and finally the citizen who has never been part of the military family. It is relatively easy to extend the privilege to the dependents of veterans, and it makes especially good marketing sense to bring in the spouses of veterans because they often make the decision on the choice of health care providers for the family. Treating spouses will also help attract sufficient women veterans to justify in-house gynecological services. Active duty service members and their dependents are also members of the veterans extended family and the progression from the DOD medical system to the VA is a natural one that captures a client base accustomed to the style of medicine practiced by VA.

Secretary Brown has said on several occasions that VA intends to contract out the

treatment of dependents -- at least initially. If being competitive in the market place is the key to the survival of VA medicine, AMVETS would like to suggest that VA re-evaluate that policy. We are not suggesting that VA start turning away veterans in favor of dependents. What we seek is the final part of the strategic plan for VA -- the programmatic information that will show how VA intends to adjust to the new realities created by the Health Security Act.

The real issue is treatment of the last category of non-veterans. We all remember the rural health care fiasco. There are those who continue to categorize the reaction of the veterans community as one of greed and short-sightedness, when in reality it was a prime example of noble intention being overcome by inept policy management. The real lesson is not that veterans groups have the power to pull a coup-de-tat. Rather, the lesson is that we simply want to be part of the planning process as new programs are designed and implemented. So let us help. Don't keep us in the dark about the implementation plans. Let the working relationship between VA and those it exists to serve act as a model of how government serves the people - not how government rules the people. There are surely some provisions that will be difficult for the veterans organizations and the members of Congress. But if the plan is presented as a coherent whole, where we can see that a loss in one area (both geographically and clinically) means significant gains in another, we can be expected to react in a manner that benefits not only veterans but the nation as a whole. But if the plan is presented as just another round of cuts in health care services, we can only react to protect the status quo. AMVETS hopes that does not happen and we await VA's implementation plan.

Section 1813 Of the Health Security Act (HSA)authorizes enrollment of family members in VA medical plans at the discretion of the Secretary. As stated previously, AMVETS supports inclusion of dependents and urges the Secretary to move quickly to capture that market.

We are gratified to see that sections 1821 and 1822 retain medical services currently offered in VA and not present in the standard benefits package and makes core and special category veterans eligible for those benefits.

Section 1823 defines the core beneficiary population and also states that core veterans shall not be charged for their enhanced medical care whether enrolled in a VA plan or not. We concur.

Section 1824 authorizes supplemental benefits at additional cost to those non-core veterans electing VA care as well as prohibiting VA from charging core veterans. Again, we concur.

Section 1825 mandates that BA seek reimbursement for treatment provided to veterans enrolled in non-VA programs. It is unclear whether the intent of this section is to include treatment for service-connected treatment. We suggest additional language specifically exempting service-connected treatment from cost recovery, and although section 1831 accomplishes that goal, this language should be included in 1825 to preclude administrative error.

AMVETS fully supports the provisions in section 1832 which authorize VA to receive payments from Medicare for the cost of non service-connected care provided to non-core Medicare-eligible patients. We also support retention of collections as described in section 1833.

However, section 1833(c) prohibits retention of funds received for treatment covered by appropriated funds. This section is unclear in its intent and needs clarification.

AMVETS concurs with the section 7341 prohibitions against imposition of additional regulation that would prevent VA from organizing itself efficiently on a regional basis. It is easy to envision a VA health plan that crosses the boundaries of several states. VA must be able to operate as a certified health plan without the artificial boundaries imposed by state lines.

Section 7342 authorizes liberal contracting and we concur with that provision. AMVETS also urges VA to look closely at the traditionally hard-to-serve areas as a market niche that will probably be ignored by the private sector as not cost-effective. If VA does move into such areas, it will be incumbent upon Congress to support such operations with additional funds because of the higher cost-per-treatment episode.

Section 7344 authorizes the secretary to enter into sharing arrangements with a wide variety of providers. AMVETS has always supported sharing agreements when they offered an expanded range of services to veterans either through the direct provision of services or creation of additional funding streams that will now be available to improve VA services in-house. For example, if VA has an MRI machine and can offer excess capacity to another plan in exchange for services not available in VA, that is an efficient use of the equipment and expansion of services to veterans. We caution, however that such services should not displace the treatment of veterans and must not contribute to increased waiting times.

We are especially pleased to see that section 7344 will authorize VA to establish alternative personnel systems. It is no secret that current personnel rules make it excessively difficult for VA to rid itself of substandard employees. VA should be allowed to hire and fire in ways consistent with the private sector. To do otherwise will inhibit VA in a competitive environment.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
GORDON H. MANSFIELD, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
PROVISIONS OF THE "HEALTH SECURITY ACT"
AFFECTING HEALTH CARE FOR OUR NATION'S VETERANS

NOVEMBER 18, 1993

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the impact of the Administration's proposed health-care reform proposal, the "Health Security Act," regarding the provision of health-care services for our nation's veterans. The President's proposal will have a profound effect on the way in which the Department of Veterans Affairs offers and provides health care services. There are many details of the plan that still need to be clarified for PVA to judge exactly how VA is expected to operate. Likewise, there are many unanswered questions on how VA health systems, facilities and employees will, and can, adapt successfully to the competitive challenges of the Administration proposal.

Paralyzed Veterans of America has supported the President's health-care reform plan only "in concept." On September 22, 1993 we informed First Lady Hillary Clinton and Secretary of Veterans Affairs Jesse Brown, by letter, that we endorsed the Administration's efforts to ensure universal health coverage, improve access and reduce the financial burden of health care for millions of Americans. We stated there were many aspects of the President's plan governing the provision of VA health care that we felt were positive improvements for the system. By comparison, no other national health care reform proposal before the Congress has addressed veterans' health care in any substantive fashion. However, we also stated that many aspects of the plan, particularly those regarding financing and access, had yet to be revealed or resolved in a satisfactory manner. Many of those questions still remain.

The September 22, PVA letter to Secretary Brown included a list of 21 questions designed to establish a dialogue with the VA to resolve many of our unanswered concerns. PVA has made numerous inquires regarding answers to the questions. To date we have not received a response. We would like to submit a copy of those questions for the record.

Mr. Chairman, we would like to highlight several areas of concern.

Financing

Mr. Chairman, the availability of funding will determine whether the VA health care system succeeds or fails. Our basic concerns center on three questions:

- Who will pay for it?
- Who should pay for it?
- In the end, will there be enough money to keep the system alive?

The First Lady and the President have promised that VA will be given the tools to make itself competitive in tomorrow's reformed national health-care system. But the question remains will there be sufficient resources, assets and flexibility to accomplish that goal. Or, will VA only be given the semblance of competitiveness and just enough rope to hang itself?

Employer-Paid Premiums for Service-Connected Disabled Veterans
The Administrations proposal would require the employers of service-connected disabled veterans enrolled in VA Accountable Health Plans (AHP) to pay 80 percent of the premium to cover the cost of that care. PVA believes this is a major violation of the traditional responsibility of the federal government to provide and cover the cost of health services for men and women injured in military service. The Administration's proposal would shift those costs to the private sector. We appreciate the Secretary's initiative to have self-employed, service-connected disabled veterans excused from paying their own premiums for VA health care. Correctly, as well, the plan prohibits the collection of third party reimbursements for the cost of treating service-connected conditions. It would be inconsistent to allow collections from employer-paid premiums which are part of the employee's own benefits package and salary given in lieu of actual compensation. We strongly urge the Administration and the Congress to extend that exclusion given to self-employed service-connected disabled to all veterans with a service-connected disability who enroll in the VA. The traditional role of the federal government, acting through the appropriations process as the guarantor of health care for the nation's service-disabled, should be maintained.

Funding Sources: Appropriations vs. Third-party Reimbursement
The "Health Security Act" would require that, upon enactment, funding for VA health care would immediately be changed from total support from appropriations to a mix of appropriations offset by funds from third party reimbursements, premiums, copayments and deductibles. Federal appropriations for the VA health care system would cover the actual cost of delivering supplemental benefits and the basic benefit package, but only to the extent that the system is not reimbursed by some other source of revenue. Appropriations would not be used to cover the cost of higher income VA enrollees.

This funding scenario is the core of the Administration's design to force VA to compete for the patients and patient dollars it must attract, to support itself rather than relying only on appropriated funds. The Administration estimates that allowing VA to retain reimbursements from all core group and higher income veterans will potentially offset appropriations by up to $17 billion over a three year period. Ironically, those funds would not accrue to VA to assist the system to recover from years of underfunding and to put itself in a better position to be more efficient and competitive. Those funds would be scored as savings to be used to pay for increased benefits for other Americans provided for in the bill. This is not fair.

VA must be able to retain reimbursements if it is going to be able to compete effectively within the context of the Administration's national health-care reform plan. However, the scenario, as described above raises three major concerns.

> Under what basis would the federal/appropriated funding share of the VA system be adjusted to reflect increased costs or improvements if the appropriation is only set to offset collections from third parties. If there is no positive adjustment in funding or regular appropriations increase, funding for VA would always remain constant - appropriations rising if reimbursements fell short and vice versa. The VA system would never be able to dig itself out of the funding hole it has slipped into over the past decade. It would never be able to successfully compete.

If non-appropriated dollars became the only source of increased revenue for the system, VA medical centers would logically be enticed to recruit the "money makers" - premiums and copayments from higher income veterans. Appropriated funding could continue to shrink at the expense of services for the core group service-connected and low income veteran patients.

Specialized services such as sustaining care, long term care and rehabilitation care provided in spinal cord injury centers, which as centers of excellence would be funded by appropriations, would also be jeopardized if appropriations were allowed to shrink.

The appropriations/reimbursement offset provides no incentive for VA medical centers to compete, improve, or expand their services, especially in the early years of enactment of the reform legislation. We understand that negotiations are currently being conducted to allow VA to retain reimbursements and appropriations at least for a limited period as well as to give VA ability to borrow capital to give the system a running chance to reinvent itself and compete successfully.

Capitated Funding

A VA health care system, funded on its ability to enroll veterans and compete with the private sector, will need a budget system that adequately provides for projected costs and anticipated utilization. Currently VA health care budgets are based on "current" services estimates. Current services estimates have been adapted for past and current VA appropriations based on broad analysis of utilization and the cost of personnel and FTEE required to meet certain service levels. Because the Office of Management and Budget has consistently underestimated medical care inflation, appropriations based on current services estimates fall nearly $2 billion short of true current services. In a scenario where VA receives funding from appropriations and third party reimbursements, presumably most third party payments would be made on capitated system. It seems logical and proper that VA appropriations also be based on a capitated system to reflect more accurately the expected cost of care for core group veterans who enroll in the system.

Risk Adjusted Per Capita Payments

Veterans currently utilizing VA health care facilities are typically sicker and older than the general U.S. population utilizing other health providers and systems. For this reason, if VA is going to be competitive, PVA believes it is imperative for capitated premiums received to help defray the cost care for core group veterans be risk adjusted.

Medicare Reimbursement

PVA strongly supports provisions in the plan that would authorize VA to collect reimbursement from Medicare for the cost of treating higher income, Medicare-eligible veterans who enroll in the VA health care system. These would be dollars that would be spent by the Medicare trust fund whether they came to VA or not. The dollars generated by such a proposal would not be great - ranging only from $50 million to $100 million per year. But we also do not see why Medicare eligible high income veterans who do not have core group VA eligibility should be denied access to the VA health care system by some restriction which disallows them to bring their Medicare dollars with them, or penalizes VA for providing that care. The hallmark of the Administration's national health-care plan is choice.

Supplemental Benefits

In many respects, due to geography, financial condition or public perception, VA starts out in the competition, required by the

Administration's proposal, at a distinct disadvantage in relation to its private sector counterparts. The differential grows wider if VA does not have the ability to modernize its facilities, extend its ambulatory care into communities and make general improvements. Beyond that VA has to be able to offer more than just the basic benefit if it is going to be able to attract and retain a stable patient base.

The "Health Security Act" specifies that VA will be authorized to provide those benefits in title 38, U.S.C., that are over and above the benefit levels contained in the Administration's basic benefit package. Core group veterans will have direct access to these services. Higher income veterans may receive them for an additional unspecified premium. This is a broad list of benefits providing expanded eligibility from prosthetics and orthototics to extended rehabilitation and long term care services. The expanded benefits are of particular concern for an older veteran population. They are a matter of essential concern and necessity for PVA members and other veterans with catastrophic disabilities. Supplemental benefits are the foundation of extended rehabilitation and specialized services provided through VA's Spinal Cord Injury Center system.

Unfortunately, the supplemental benefits package is the most vulnerable ingredient in the VA's projected health-care plan. The supplemental package would be the first to go if dollars became scarce and VA was forced to channel a higher level of appropriated dollars to support basic benefits for core group veterans. Certain VA medical centers may have authority to ration supplemental benefits.

PVA strongly believes that supplemental benefits traditionally offered by VA should be defined and made a matter of standard policy for all VA medical centers. They should be an integral part of the health plan offered by those facilities. Just as the basic national benefit would be defined by the "Health Security Act" we believe that VA supplemental benefit package should be clarified by amendments to title 38, U.S.C., as well. Extended and long term care provided in VA spinal cord injury centers should be part of the statutory definition.

Long Term Care

The ultimate mission of the Department of Veterans Affairs health care system will be the provision of extended and long term care services for a veteran population that is growing older and staying older longer than ever before. It is inconceivable that VA is facing major reforms contained in the Administration's plan without one word addressed to improve or even define the system's current and future long term care mission.

Eligibility reform, providing access to veterans to a full continuum of care - inpatient, outpatient and long term care services - remains a primary concern for PVA. PVA is committed to the realization of this goal whether within the Clinton proposal or by other means. The Administration proposal has addressed the question of outpatient services by extending eligibility for veterans to receive the basic benefits called for in the larger plan. That is a step forward, as long as the scope and extent of those services is not reduced in the Congressional debate over the plan or in the future.

Long term care for veterans has been limited. As depicted above, long term care has been segregated among the VA supplemental benefits and is highly vulnerable to the vagaries of budgetary squeezes and appropriations shortfalls. For this reason, PVA supports two initiatives that would correct this oversight:

"Veterans Long-Term Care Act of 1993"

PVA would like to thank the Ranking Minority Member, the Honorable

Bob Stump, for introducing H.R. 3122, the "Veterans Long-Term Care Act of 1993." The legislation would, for the first time clearly define the long term care mission for the VA. It would identify those veterans who would be eligible to receive long term care services from the VA. The Administration's reform proposal clarified eligibility for basic outpatient and inpatient services for veterans utilizing VA. The bill introduced by Representative Stump would fulfill the entitlement reform goal endorsed by every major veteran service organization in seeking the full continuum of care for all veterans through the provision of clear access to long term care services. PVA believes the legislation is an important first step in this process.

Briefly, the legislation provides mandatory long term care services to certain veterans with service-connected disabilities, and very poor and permanently disabled veterans. It would authorize VA to provide long term care services to other veterans through the establishment of long term care insurance policies and the collection of premiums and copayments. It would establish innovative contracting and sharing agreements for long term care services. The bill would also authorize VA to establish "veterans' continuing care centers" in cooperation with the private sector or non-profit entities to increase access to long term care services. It would also accomplish a major PVA goal by establishing a VA program for assistive home-based services for severely disabled veterans designed to avoid increased costs and unnecessary institutionalization.

Mr. Chairman, this is innovative and needed legislation. We strongly urge the Subcommittee to give this initiative every consideration.

Administration's Proposal: State Programs for Home and Community-Based Services

Mr. Chairman, of equal importance is a proposal contained in Title II, Subtitle B of the Administration's "Health Security Act" which would authorize states, with the support of federal funding, to establish programs of community-based and home-based care programs for severely disabled individuals. The Administration has designed this innovative initiative to give the states the freedom to establish their own programs tailored to meet the needs of their own communities and citizens with disabilities.

The program would authorize services for severely disabled Americans experiencing limitations in at least three activities of daily living. These individuals and their families could receive a variety of home-based, community-based care and respite services to help promote the home and family as the best and most efficient alternatives to long term institutionalization for many severely disabled individuals.

Mr. Chairman, for seven years PVA has been a member of the Long Term Care Campaign, a coalition of over 137 national organizations representing more than 60 million Americans. We are also a member of the Consortium of Citizens With Disabilities Task Force on Personal Assistive Services (PAS). Enactment of these long term care provisions is a major goal for PVA and both major coalitions. We encourage every member of the Subcommittee to support this program.

Access to Spinal Cord Injury (SCI) Care

At the present time, a VA eligible veteran with a spinal cord injury who does not live in the immediate catchment area of a spinal cord injury center can receive authorization from the nearest VA medical center to go to a specialized SCI center and receive care. Often, spinal cord injured veterans can also travel great distances to receive specialized SCI care that might be available at one SCI center but not at another. Flexibility in

providing access to SCI veterans is a necessity in adapting a service delivery model to a center of excellence SCI system structure.

PVA is greatly concerned that such flexibility would not be a part of a restructured VA system. The "Health Security Act" requires VA to establish a VA plan in all health alliances and be an enrollment choice for all veterans. VA would be required to provide basic services in each of its plans. However, each VA health plan would not necessarily have the ability or the expertise to provide comprehensive SCI care. Concerned over that fact, PVA asked VA in our series of questions (Question 5) under what circumstances a veteran enrolled in one VA AHP could receive specialized SCI care in another.

PVA strongly urges this Subcommittee to consider legislation mandating authority for an eligible veteran to be transferred from one VA AHP to another to receive required specialized services, including care at spinal cord injury centers.

VA Ability To Adapt To Service Delivery Model

Reorganizing the structure of the VA health care system and providing sufficient funding to support the provision of services are important technical steps in reinventing VA to adapt to the competitive environment of national health care reform. However, VA will have to do far more than just reorganize itself to prove to the veteran population that it can provide a quality health care product in an efficient manner. The proof of VA's success will be its ability to attract and retain a stable patient base. In doing so it will have to provide a quality health service, not just patient care.

At the present time, VA has a "captive patient" population that includes veterans who have no other alternative for services needed or who do not have the resources to pay for their health care elsewhere. Unfortunately, in many locations, VA medical centers have looked upon this patient population with far too much bureaucratic insensitivity. In too many instances, veterans seeking care from VA are treated more as an inconvenience than a valued customer. Unfortunately, once more, this perception of poor service is well known in the veteran community and appears to be a common view of the system by the general public as well.

PVA has recently completed a series of focus groups in the attempt to gauge public and veteran perception of the VA health care system. This process, led by a professional facilitator, selected representational groups of veterans, both VA users and non-VA users, from representational VA catchment areas. In summary, the focus groups repeatedly addressed two points.

1. Veterans seeking health services or a health plan determine quality of care for the most part on how they are treated, not what kind of treatment they are given. The amenities of a health care provider, waiting times, distances travelled etc. are a primary concern.

2. VA has a long way to go to change many of its current practices if it going to be able to compete with the private sector regarding patient satisfaction.

Such changes in attitude and function cannot be made part of any national health care reform proposal. These improvements have to start at the VA medical center level. They can be achieved only as a direct result of improvement in management. They should be implemented by VA managers and employees regardless of the passage or failure of any one health care reform proposal. PVA would be pleased to make the findings of our focus groups available for the Subcommittee to review.

Conclusion

Mr. Chairman, all of PVA's members are veterans who have sustained catastrophic spinal cord injury, disease or dysfunction. The nature of these disabilities requires constant, comprehensive and long term health monitoring and supervision. Nearly 60 percent of PVA's membership rely on the Department of Veterans Affairs (VA) for care and treatment provided primarily through its network of spinal cord injury centers. No other health care system in the United States can duplicate the VA SCI network in the provision of comprehensive, long term services required by veterans with these disabilities. As VA adapts to the pressures of national health care reform it is imperative that a strong SCI system, backed by comprehensive VA acute care network be preserved and that veterans with these disabilities can retain access to those services. The Department of Veterans Affairs health care system, and its centers of excellence for spinal cord injury care, can succeed in the process of health care reform, but only if the system is given the proper tools. We ask for the members of this Subcommittee to be vigilant as this debate continues.

Thank you for your continuing support. I will happy to answer any questions that I can.

DEPARTMENT OF VETERANS AFFAIRS

RESPONSE TO QUESTIONS
by
PARALYZED VETERANS OF AMERICA
on
NATIONAL HEALTH CARE REFORM

QUESTIONS PERTAINING TO THE ADMINISTRATION'S DESCRIPTION OF "AMERICAN HEALTH SECURITY ACT OF 1993"

Q1. From our point of view the VA cannot effectively compete under health-care reform unless those veterans who are basically eligible to use the VA now at Government expense can have access to the full range of VA services and programs. That does not happen today, except for some service disabled veterans, and even then they are not entitled to nursing home care in VA. How would the Administration's plan support a change in the VA medical care rules so that VA can begin to deliver cost-effective health care in a manner consistent with good medical practice and sound medical ethics?

A1 The Administration's plan guarantees the full comprehensive benefits package for all veterans who enroll in the VA Plan. The benefits package includes comprehensive outpatient and hospital services, durable medical equipment, most custom fitted prosthetics, rehabilitation services and home medical services, as well as drugs and medical supplies. Creation of VA health plans within the context of the national health reform proposal will effectively result in broad eligibility reform for the VA health care system and will allow all veterans true access to the VA for the first time.

Q2. In the Administration's health care reform proposal it states that "veterans with service connected disabilities and low income veterans will continue to be eligible for supplemental benefits not included in the comprehensive benefits package, such as treatment for post traumatic stress disorder and certain dental services at no cost to these individuals":

1. "Veterans with service-connected disabilities and low income veterans" excludes special category veterans - veterans from WWI, POW's, those exposed to ionizing radiation or Agent Orange. Is that intentional or are these veterans still considered to be entitled to VA benefits under health-care reform?

2. We feel that catastrophically injured/disabled veterans should also have access to VA services to obviate poverty spend-down in the same manner as means-tested low-income veterans. How would the Administration's plan provide coverage for these veterans?

3. The examples of supplemental benefits in the text of the proposal are limited to post-traumatic stress disorder and "certain dental services". Is the intent to make available all the specialized services currently provided by the VA or to limit the availability of such services? We are particularly concerned about programs of acute care and institutional and non-institutional long-term care for the spinal cord injured veterans, prosthetics, orthotics, and durable medical equipment (DME). Does the proposal intend to cover such services?

A2.1 Former POWs and WWI veterans who enroll in the VA Plan will not pay any additional premium, copay or deductible payments. Veterans who enroll in the VA Plan who are being

treated for conditions possibly related to exposure to Agent Orange or to ionizing radiation will not be subjected to any copays or deductibles for treatment of that condition.

2. The Administration preserves the VA's definition of low income for veterans which allows veterans to retain assets and income not available to the public. For example, a veterans home is not considered as an asset for the VA means test. The way the VA defines low income for VA eligibility purposes obviates the poverty spend down experienced by many other citizens who are catastrophically injured.

3. The VA will continue to provide those services not included in the national benefits package that the VA now provides under current eligibility. For example, the standard benefits package does not include eyeglasses or hearing aids for adults. Service-connected and low income veterans who are now eligible for prosthetics from VA would continue to be able to obtain custom fitted devices like eyeglasses and hearing aids at no cost from the VA under current eligibility. The VA would continue to provide dental care to currently eligible veterans even though dental care is not included as a standard benefit. In addition, the VA may offer these supplemental services to other higher income veterans for an additional premium.

Q3. The Administration's proposal contains the statement that non-veterans "are not eligible to enroll in a VA health care plan or to receive services on a contract basis from a VA health plan," except for dependents of veterans currently eligible under CHAMPVA:

1. Current law gives (P.L. 102-585) gives the Secretary the authority to enter into sharing agreements with the Department of Defense to provide health care for CHAMPUS beneficiaries. To what extent is VA currently exercising that authority? Does VA anticipate that this sharing program will be expanded in the future?

2. Under current law multiple VA medical centers have consummated sharing agreements with military hospitals, the Indian Health Service, affiliated academic medical centers, and community health care facilities in which non-veterans may receive VA health care services on a *quid pro quo* basis. Is it the Administration's intention to nullify those sharing agreements? Are more sharing agreements to be implemented?

3. There are DOD/VA joint ventures involving both hospitals and clinic facilities for common occupancy and shared services. More are in the planning stage. Are these to be discontinued?

A3.1 VA is in the process of negotiating the first agreement of this kind between VAMC Asheville and DoD. Use of this authority may be expanded to other facilities in the future but only if it can be demonstrated that veterans will benefit from the agreement and if there is no objection from VSOs.

2. These agreements will remain in effect. The Secretary has stated that he would endorse additional agreements considered for ancillary services, such as lab and x-ray.

3. There is nothing in the Administration's proposal that would prohibit these kinds of arrangements from being considered. VA will be considering many options as implementation plans for VA health plans are discussed.

Q4. The Administration's plan states that the VA Secretary may determine if a VA health plan offers family coverage to the dependents of veterans.

1. For the VA to be successful in the competitive medical market the inclusion of veterans' families in a VA/AHP, as would be the case in the competing private medical sector plans, becomes a critical issue. Should not such authorization be specified in the Administration's plan to make the VA competitive and to be consistent with authority given which allows VA to retain reimbursements for services provided (according to the Administration's proposal) to veterans and their dependents enrolled with a non-VA health plan for care provided in VA on a contract basis?

2. Does not the inclusion of health care in VA facilities for active duty dependents through VA/DoD sharing agreements with CHAMPUS serve as a precedent for veterans' dependents to receive equitable consideration?

A4.1. Under the President's proposal for health care reform, the Secretary may open care to dependents of veterans.

2. If the Secretary decides to offer enrollment in the VA plans to veteran dependents, CHAMPUS dependents may enroll in VA plan as the dependents of veterans enrolled in VA plans. If the Secretary decides to offer dependent enrollment, enrollment in VA plan would be limited to veterans, including military retirees, and their dependents.

Q5. If a veteran with a spinal cord injury enrolled in a VA AHP with facilities that did not contain a spinal cord injury unit, under what basis would that veteran be transferred to another VA AHP that did have the specialized SCI services the veteran required?

A5 All VA health plans would have to ensure access to appropriate quality services for plan enrollees. Guidelines for plan operations, including patient transfers, will have to be developed for all VA health plans.

Q6. The Administration's plan states that veterans with service-connected disabilities and low-income veterans will continue to be eligible for supplemental benefits not included in the basic benefit package, and that VA may also offer these supplemental benefits to higher-income veterans at an additional premium.

1. We take it, by implication, this statement refers to veterans who have enrolled in a VA/AHP. If so, we ask that authorization also be given for veterans not considered Category A (or "core-group" veterans and the catastrophically disabled), who have for some reason enrolled in a non-VA AHP, to opt out when in need of certain VA supplemental services. Under the Clinton proposal, Medicare managed care program beneficiaries are to have such an option. In many cases, such specialized VA programs as spinal cord injury, blind rehabilitation, PTSD and care for chronic mental illness are not comparably available in the private medical sector.

A6 The availability of such specialized programs in the VA system should be one of the factors veterans consider when making their choice of a health plan and may be a reason for veterans to choose enrollment in the VA Plan.

Q7. The Administration's proposal states that employers of all employed veterans enrolled in a VA health plan pay the employer contribution.

1. We submit this statement lacks clarification. Surely Congress is not expected to renege on its historical commitment to provide, through appropriated funds, all medical care for service-connected veterans. What if the service-connected disabled veteran is self-employed? Should he or she be required to pay his or her own premium?

2. Employee benefits (including health insurance) are recognized to be part of a compensation package (in lieu of salary). In that sense, under the VA plan it would actually be the employee service-connected disabled veteran, not the employer, who would be relieving the federal Government of the cost of his or her VA health care.

A7 The details of the proposal with respect to the relationship between appropriations and other sources of revenue under reform are being revised at this time. In addition, details of the VA Investment Fund are currently being worked out. When completed, we will provide you the details.

Q8. In those areas where no VA AP or VA plan is readily accessible or available where, and under what process, will the service-connected disabled veteran or the low income core group veteran receive care?

1. Are there any circumstances under which a core group veteran would be required to pay a co-payment?

A8.0 The last draft of the Health Security Act requires the VA to establish a VA plan in all health alliances and be an enrollment choice for all veterans. VA plans may deliver services to enrollees through a variety of delivery mechanisms such as VA staff or through establishment of a preferred provider network.

1. No.

Q9. The Clinton plan states that Medicare may reimburse VA health plans and centers for services to higher-income veterans eligible for Medicare. The Secretary of the Department of Veterans Affairs and the Secretary of the Department of Health and Human Services will undertake negotiation to determine the application of Medicare rules and rates of reimbursement for VA services.

1. For some time VA, under Congressional guidance has been exacting third party reimbursement from private insurance companies under policies held by all veterans receiving VA delivered health care, with the exception of care for service-connected illness or disability. Is it consistent to limit Medicare reimbursement for VA services provided only to non-core high-income veterans?

A9 The President's proposal allows the VA to retain all collections from health alliances and from other plans for services rendered as well as from Medicare for services to higher-income veterans.

Q10. **The proposal states that VA facilities will be able to retain cost-sharing paid to VA by individuals or employers as well as revenue obtained as reimbursement by third-party payers. At the same time the plan indicates that "Federal appropriations for the VA health care system cover actual costs of delivering the comprehensive benefit package for which the VA health plan is not reimbursed by other sources of revenue. (emphasis added)"**

1. Does such an arrangement actually provide additional revenue for the VA system, or merely provide new sources of revenue substituting existing appropriations and maintaining the funding status quo?

2. Does this additional source of funding create a disincentive for treating service-connected and low-income veterans whose care would be covered by shrinking appropriations while favoring care for higher-income veterans who would bring premiums and copayments with them to the system?

3. Will underutilized facilities receive operating subsidies because of shortages of patient populations?

A10 The details of the proposal with respect to the relationship between appropriations and other sources of revenue under reform are being revised at this time. In addition, details of the VA Investment Fund are currently being worked out. When completed, we will provide you the details.

Q11. **Recent studies conducted by PVA indicate that veterans express reluctance to change providers even when offered strong incentives, such as dental or optical services, long-term care, and lower out-of-pocket costs, for doing so. The Administration offers fewer incentives to veterans who may, for the first time, have the opportunity to select VA as a care provider.**

1. Is it the Administration's belief that there is a considerable "new" market of veterans who will change providers to enter VA without strong incentives to do so?

A11 All health plans in the health alliances will be essentially new offerings. All plans will have to provide the same benefits with objective quality comparisons. We believe that the VA Plans will compare favorably with other plans and will be an attractive choice for veterans.

Q12. The Administration's proposal claims that VA will follow the requirements of all AHPs. Will VA receive risk-adjusted per capita payments for its core group veteran beneficiaries?

A12 The details of the proposal with respect to the relationship between appropriations and other sources of revenue under reform are being revised at this time. In addition, details of the VA Investment Fund are currently being worked out. When completed, we will provide you the details.

Q13. The proposal states that "health plans organized within the VA system conform to the requirements and standards for all other health plans." What are the requirements and standards they must conform with?

A13 As decribed in the Health Security Act, requirements and standards for all health plans are to be determined by the National Health Board.

Q14. What if the VA plan does not meet specified requirements? Will the VA then not be an enrollment choice for veterans in that area? The implications are that veterans will have to enroll in a non-VA plan - they will not have the VA option.

A14 The VA is required to operate VA Plans in all health alliances under the Administration's proposal. VA Plans will not be required to meet requirements for plans that are in conflict with Federal law or regulations otherwise applicable to VA operations. We do not foresee any difficulty in VA being able to generally comply with plan requirements.

Q15. What happens to VA health plan if a critical mass of veterans fails to enroll in a VA plan? What happens to the VA program in that area?

A15 The Health Security Act requires the VA to operate plans in all health alliances.

Q16. If CHAMPVA dependent can enroll in a VA health plan, why not include dependent of veterans as family coverage? The CHAMPVA dependents are not shown in the plan's priority list. Where do they occur in the priority of eligibility?

A16 CHAMPVA beneficiaries have a different status from that of other veteran dependents in that they will be able to choose enrollment in the VA plan based on their own unique eligibility. Enrollment in VA plans will be open to all veterans and CHAMPVA beneficiaries.

Q17. Please list the supplemental benefits that are likely to be available for purchase by high-income veterans who choose to enroll in a VA health plan.

A17 Supplemental benefits that might be offered will vary from locality to locality. Some examples of types of plans that might be offered are a dental plan, or a plan for custom eyeglasses and hearing aids. Whether a supplemental plan is offered for purchase or not probably will depend on demand for the service and its availability.

Q18. Under health care reform, appropriations will be made to cover the difference between the actual costs of delivering the basic benefit package and reimbursements, plus some additional amount for supplemental benefits. This being the case, there is absolutely no incentive for the VA system managers to enroll veterans and expand programs since, even though they will be able to retain reimbursements, they will be offset in their totality by appropriations. Thus, the system will likely be further squeezed - right out of existence. Please comment on this.

A18 The details of the proposal with respect to the relationship between appropriations and other sources of revenue under reform are being revised at this time. In addition, details of the VA Investment Fund are currently being worked out. When completed, we will provide you the details.

Q19. The provisions of Chapter 27 of Title 38 USC governing VA health care will remain in effect at any VA center not functioning as a health plan. If all people must enroll in a health plan, and if veterans enrolled in a non-VA health plan cannot receive any of their basic benefits in VA (unless under contract with the VA) then who would be using the medical centers not in a VA health plan?

A19 This provision is intended to cover the phase-in period of the national health plan for VA facilities in areas where health alliances may not have been established.

Q20. How do the Administration and the Congress plan to provide the initial investment to revitalize the VA infrastructure to provide access to the additional benefits and services provided in the reform proposal - particularly in the area of additional outpatient services and beneficiary travel benefits. Will the $1 billion medical equipment backlog also be addressed in budget requests?

A20 The details of the proposal with respect to the relationship between appropriations and other sources of revenue under reform are being revised at this time. In addition, details of the VA Investment Fund are currently being worked out. When completed, we will provide you the details.

Q21. The plan would require employers of core group veterans to pay 80 percent of the cost of the premium for the VA basic plan. Is there any requirement for the core group veteran who enrolls in the VA AHP to pay the balance 20 percent co-premium?

A21 No.

Testimony of Samuel V. Spagnolo, MD
Subcommittee on Hospitals and Health Care
November 18, 1993

Good morning Mr. Chairman, Members of the Committee. My name is Samuel V. Spagnolo. Though I am employed by the VA as Chief of Pulmonary Diseases at the Washington, DC, VA Medical Center, I appear here today as the President of the National Association of VA Physicians and Dentists (NAVAPD). Thank you for giving me this opportunity to testify about reform of our Nation's health care system as it effects the veterans of our country.

The 14,000 physicians and dentists of the VA system, represented by the National Association of VA Physicians and Dentists, are, as a group, uncommonly dedicated medical professionals. Their first concern is the quality of the care they deliver to their patients. As Chief of the Pulmonary Diseases Section at the Veterans Medical Center of Washington, DC, and having served in the VA medical system for over 20 years, I can testify to this concern from the first hand experience of working with many doctors in the system over the years. I have seen innumerable examples of their unselfish dedication and willingness to contribute even under conditions that are often difficult.

But there is also even more objective evidence.

As members of the Committee are aware, studies by the General Accounting Office have shown that we deliver quality health care at significantly lower cost in the VA Medical System when compared to the private sector. This, in itself, speaks well of the system, and in my opinion, is a demonstration of the dedication of the medical professionals who make up that system.

These individuals are highly trained, respected professionals, many of whom also are affiliated with prestigious medical schools. Yet they devote all or a portion of their time to our veterans, giving them top quality care at much lower compensation than they could command elsewhere. This is a major reason that Congress and the nation can point to the efficiency and quality of the VA system as a model, in the midst of controversy over the skyrocketing cost of health care for the rest of the nation.

More direct evidence was received in a recent survey that NAVAPD itself conducted as a means of assuring that our objectives and goals were truly representative of VA physicians and dentists. We had nearly a 15 percent response that was a cross-section of the whole system. Overwhelmingly, this survey showed that "improving patient care" remains the top priority of the medical professionals in the VA system. Of the physicians and dentists responding to the survey, a full 91% directed that their professional association, NAVAPD, take a strong position on the need to improve patient care above all other considerations.

Contrary to the negative images some outside of the VA may hold, the issue of quality of care far surpassed interest in "immediate pay increases", which received only 65% positive responses. An even lower percentage felt they were overworked. VA professionals consistently supported other issues related to the quality of patient care as well, such as improving VA research funding (83%) and "encouraging university affiliations" (79%).

The VA medical system provides services to more than 20 million outpatients and nearly one million hospital inpatient episodes each year and is the largest health care system in the nation. Yet it is a system that is in trouble. By any count, it has received inadequate funding to maintain the highest quality of care possible for all of its activities over the last few years. Congressman G.V. "Sonny" Montgomery, Chairman of the House Veterans' Affairs Committee wrote recently in the NAVAPD Newsletter, "(the) VA faces a number of health care delivery problems that stem from more than a decade of deficient medical care budgets". In short, the system has reached the limits of even our dedicated professionals' ability to do more without the necessary resources. And in the midst of this, we are faced with the insecurity stemming from the potential for enormous change due to health care reform and changes in the nature of the veteran population.

We are reviewing and evaluating the numerous proposals for health care reform that are currently being discussed. All have worthy components; none are particularly detailed about where and how the current VA health care structure is integrated and financed by reform. We would like to be a part of any reform efforts and hope that today's discussions will commence a dialogue so that we can be of assistance to you.

Before the members of this committee make recommendations regarding the impact of health care reform on the VA, we think there are many issues yet to be fully evaluated. We believe that it is very important that you continue to look ahead to the future health care needs of all veterans. The important future demographics and needs of veterans should be part of your deliberations.

In our more than 170 medical centers, 368 outpatient clinics, 130 nursing home care units plus counseling and treatment centers, we currently serve about 10% of the veteran population. The acute care workload is declining 1-3% annually. Inpatient census is also declining.

Veterans are no different than rest of population; we are all aging, and veterans will be even older. Fifty percent of all living veterans (27 million) are older than 56 years; (women veterans are younger and their age is decreasing); 10% of all VA patients today are over 75 years old. By the year 2010, there will be only 20 million veterans, a 24% decline.

The number of veterans aged 75 and older will increase 193% during next two decades. In just 7 years, by 2000, 3.8 million veterans will be over 75, over twice the current number, peaking at 4.5 million by 2008; based upon these projections, 1 of every 4 VA patients will be over 75 years old by 2010. By 2015, 50% of all veterans will be 65 and older.

Be aware that studies have demonstrated that with employer-mandated health care reform packages that are being discussed, it is expected that inpatient demand at the VA will be lowered 18%. This will have a tremendous impact on numerous facilities; we should be able to plan ahead for system restructuring.

Veterans are also relocating and by the year 2010, California, Texas, Florida, Arizona, New York and Pennsylvania will be home to 1/3 of all veterans. Clearly, the medical care needs and problems of future VA patients will be different. NAVAPD sees several important issues arising from this demographic data. We believe there is an opportunity here, as you discuss health care reform, to address several issues, and we would like to make the following suggestions.

We believe the areas of concern fall into the following categories: access and eligibility, quality of care, financing, and restructuring. All our assumptions rest on the fact that you will retain the current policy that the primary responsibility of the VA system will be to continue to serve the needs of veterans who have service connected disabilities and/or are low income.

- Access to VA care must be revamped by simplifying eligibility requirements.

- Patient care should be improved by developing more affiliations with medical schools, sharing agreements with DOD and others, and creating centers of excellence for treatment and research in areas where the VA currently excels, e.g., spinal cord injury, prosthetic research and rehabilitation, mental illness, substance abuse, and long term care. There should be an emphasis on geriatric units and more focus on the elderly. Further, there should be new approaches for delivery of quality of care to veterans in rural areas. The VA has some of best medical research and training in the world and NAVAPD feels strongly that the VA commitment to medical research and education for the health care professional be maintained. These vital missions play an important role in maintaining the quality of patient care as well as the retention of outstanding physicians, dentists and other health professionals. However, the time has come when the Congress will have to decide to improve these activities or shut them down unless adequate resources are identified to pay for them.

- Steps must be taken to increase the flexibility and rationality of resource allocation within hospitals. We support the principle of reimbursement based upon services provided just as in the private sector and that resources be equitably and rationally distributed based upon productivity and quality of service. VA physicians fear that managed care means simply, more of the same management and less care.

■Even while the number of veterans is shrinking many individuals may wait weeks for vital services. For the VA to compete in the future, it must not only upgrade equipment and physical surroundings it must rid itself of the institutional mindset that has bred bureaucracies that clog and distort the decision making process.

The physicians and dentists of the VA recognize the need for health care reform and support reorganization of the veterans health care system to meet the changing needs of the veteran population. We, in fact, as we have in the past support any effort to improve the quality of patient care within the resources available.

I am proud to represent the many professionals who do not take their responsibilities lightly and who are dedicated to giving their patients the best care as efficiently and economically as possible. It is this group of dedicated people that come before you today. Thank you.

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Statement of

Nurses Organization of Veterans Affairs

NOVA

By

Bette L. Davis, MSN, RN, CS
President

Before the

Subcommittee on Hospitals and Healthcare
Committee on Veterans' Affairs
United State House of Representatives

On

VA'S ROLE IN NATIONAL HEALTH CARE REFORM

November 18, 1993

Mr. Chairman and members of the Subcommittee, I am Bette L. Davis, MSN, RN, CS, a clinical nurse specialist at the Washington, D.C. Veterans Affairs Medical Center and President of the Nurses Organization of Veterans Affairs (NOVA). Thank you for inviting NOVA to testify today on President Clinton's health care reform proposal, the "American Health Security Act of 1993", and on the role of the VA within the comprehensive VA Health Plan. We appreciate the opportunity to work with this Subcommittee and acknowledge the Chairman's longstanding record and commitment to veterans health care.

The Nurses Organization of Veterans Affairs was created because of a need for VA nurses to have an active legislative voice in improving health care for U.S. veterans. The need is greater than ever, because the time has come when every American citizen can expect major policy changes, in both the private and public health care sectors under a national health care reform plan. Thus, NOVA is committed to improving veterans health care and the delivery of nursing care to veterans and to all Americans.

In general, NOVA commends President Clinton's comprehensive health care plan. It is designed to provide universal health coverage to those Americans who do not now have insurance or are underinsured, while at the same time, curb health care costs. The plan raises hopes and concerns, but NOVA agrees that the status quo is no longer acceptable. The proposal addresses factors of access, quality of care and affordability.

Specifically, NOVA applauds the President's plan for the VA to continue as an independent health care system, managing VA Health Plans within regional health alliances which will provide a comprehensive national benefits package to all veterans who enroll in the VA Plan. This is positive recognition of VA's mission and capabilities to encompass the full continuum of health care. Clinton's plan for the VA will move us in the right direction as it is designed to increase VA resources and access to VA facilities not now available. This is an opportunity to help the VA improve its weakest areas. VA nurses are prepared to face the challenge and call for an end to confusing eligibility rules and inadequate resources at the point of care.

NOVA supports the following KEY ELEMENTS of the VA Plan as it will enable the VA to focus on primary/preventive care and health promotion across the life span of veterans, with services delivered in community based settings.

KEY ELEMENTS OF THE VA HEALTH PLAN
UNDER THE AMERICAN HEALTH SECURITY ACT

Overview of Enrollment in VA Plan:

- o VA will organize and operate VA Health Plans within Health Alliances which will be open as an enrollment choice to all veterans who live in the geographic area covered by the plans.
- o VA Plans will provide all veterans who are enrolled the same comprehensive standard benefits package, including comprehensive outpatient care that other plans will provide their participants.
- o Service-connected and low-income veterans who choose a VA plan will receive care without payment of premiums, co-payments or deductibles.
- o Service-connected and low-income veterans remain eligible for free care from the VA for extra VA services traditionally provided, such as long term care, PTSD treatment, custom prosthetics, and comprehensive rehabilitation as defined in current law, but not included in the standard benefits package.
- o Higher income nonservice-connected veterans enrolled in a VA Plan will be required to pay a cost share of co-payments and deductibles for care under the same rules that apply to other health plans. Supplemental benefits not covered by the standard benefits package may be purchased for an additional premium payment through the VA Health Plans.
- o The secretary has the option to include veterans' dependents in VA Plans.

Other National Roles

- o The VA system continues its significant role in national education for health care professionals and in national research.
- o VA continues to serve as back-up to DOD in time of war or emergency.
- o VA facilities may serve as provider to other plans and to Medicare on a reimbursable basis.

Financial Features

- o VA will receive premium payments from Health Alliances and employers for veterans selecting the VA Plan.
- o Higher income nonservice-connected veterans will pay cost shares (copayments, deductibles, additional premiums).
- o Medicare will reimburse VA for higher income nonservice-connected veterans.
- o Other non-VA health plans would reimburse VA facilities for standard benefit services given to members of those plans.
- o Appropriations will cover the applicable cost of all care for service-connected and low income veterans.
- o VA will be able to retain all reimbursements and collections.

TRANSITION AND IMPLEMENTATION ISSUES

Access to Health Care Coverage

Eligibility

Current strict eligibility requirements and increasingly tighter budgets force a growing number of veterans to seek health care elsewhere. Lack of entitlement to care also cripples nursing practice and continuity of care for veterans. Understaffing and lack

of resources encourages other veterans to seek treatment elsewhere. Clinton's plan will simplify eligibility rules and restructure the VA for equitable health delivery arrangements. It will increase VA's ability to compete in providing a comprehensive package of benefits with no lifetime limits on coverage.

Cost

Today's VA system cannot obtain reimbursement from Medicare or private insurance for all veterans care and is entirely dependent upon Federal appropriations for funding. Under the President's proposal, the VA health system will have access to additional funding sources such as employer contributions and Medicare reimbursements. None of the other legislative proposals for health care reform provides additional resources for the VA medical system.

Appropriate Settings

Access to health care would be improved for veterans living in rural and urban areas that are currently undeserved, or for those who have special needs that limit the distance they can travel. Under Clinton's plan, health alliances may arrange favorable financing incentives to encourage a health plan to expand into areas with inadequate health services. NOVA supports all efforts to increase access to veterans through innovative sharing and outreach services with both federal and private sector facilities and health care systems. VA's rural outreach clinics and MediVan Clinics to provide outpatient services can be supported by medical centers and visiting health teams to see patients and consult with professional staff. As more health care is given in ambulatory settings, nurses can cross - train or re-train in these areas.

Primary/Preventive Health Care

The Administration's plan recognizes that primary and preventive health services are crucial to any restructuring of health care delivery. The single most important change in the VA health system will be to move from an emphasis on an "illness care/cure" modality to a continuum of care that provides primary and preventive care services. Under the President's proposal the health care setting could be restroctured and reoriented for services to be available in community settings as well as in institutional settings.

Public Health Focus

NOVA also commends the plan's focus to deliver personal health care services with the delivery of public health services. This would help support community prevention programs and the coordination of public health activities such as data collection and disease investigation and control. It will also assist the VA in its efforts to motivate and educate individuals to reduce risks to health and to intervene earlier for preventive care.

Primary Care Providers

NOVA applauds the Clinton health plan for addressing an increased need for primary care providers in order to ensure accessibility and availability of primary and preventive health care services. The Health Security proposal asks for increased funding for primary care providers -- including advanced practice nurses such as nurse practitioners (NPs), and certified nurse midwives (CNMs). Health care reform will reinforce the role of nurses as providers for primary/preventive care, acute care, mental health care, and long term care in multiple settings such as ambulatory care, acute care/geriatric and long-term care facilities, and homes. Primary health care providers focus on managing current health care needs, preventing future problems and referring to other providers and specialists when appropriate. Some essential primary health care services include:

- performing physical exams and taking health histories;
- assessing and evaluating common symptoms of acute illnesses such as colds and infection;
- managing chronic health problems such as diabetes, high blood pressure and depression; and,
- screening and identifying health needs that require referral.

NOVA supports the President's proposal to provide a cost-effective mix of providers through increased reliance on and access to advanced practice nurses. Published studies show the cost-effectiveness and quality care of using these nurses in all settings. Some 60% to 80% of primary and preventive care traditionally done by doctors can be done by nurses at lower cost and of the same quality as physicians.

NOVA also supports the removal of barriers restricting nursing practice and reimbursement . Laws regarding reimbursement for advanced practice nurses are complex and irrational as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who receives the payment, and whether or not collaboration with other health providers is mandated. Equally, laws and regulation in many states put unnecessary limits on the practice of nurses, such as advanced practice nurses, to provide services to patients. To ensure that health providers are treated equitably, the Clinton plan calls for a removal of these restrictions on nursing practice and payment for services of advanced practice nurses.

Managed Care

The core of the health care reform is the use of managed care services which are utilized to integrate, coordinate, and advocate the delivery of health care for individuals with primary care as its focus. It also focuses on wellness and preventive care, not rationing, to cut costs. The VA health care system is a quasi-health maintenance organization with a managed care mode of health care delivery. Unfortunately, the VA system has lacked funding to provide comprehensive, more holistic care, to veterans

with complex health care needs. Unfortunately, within the VA, like in many tertiary/teaching health centers, inpatients are treated by a number of physicians, in a fragmented way, and may not have a designated primary care provider and adequately followed-up as an out-patient.

NOVA is pleased that the VA is developing and moving toward a managed care environment with primary care as its focus. We believe a significant investment initially will enable the VA to restructure and change distribution of VA resources, enhancing our ability to deliver primary care and improve the physical infrastructure of many facilities. Any cuts for start up and continual programs will severely affect VA's ability to complete.

Most Americans probably prefer to select their own provider of health care if given a choice, but more are likely to enroll in managed care plans instead of fee for service plans because of escalating costs. Even now, insured veterans, including those with Medicare, utilize both VA and non VA resources for care. Of the one-fifth uninsured Americans, 85% of them are workers with families. Not all veterans are homeless, derelicts or substance abusers as portrayed in the media myth of veterans. A survey at the Dayton, OH VAMC reveals that 68% of their outpatient population is married, with another 14% living with a significant other or relative.

The use of registered nurses as case managers to be the coordinator and synthesizer of care would provide continuity of care, reduce case backlogs, facilitate earlier rehabilitation and improve access. Community health nurses provide important linkages with urban and rural resources, crossing barriers and connecting veterans with better coordinated care in the home environment.

The cohesion of a primary group of providers would promote any interdisciplinary approach, decrease professional turf issues, and better consolidate available resources. With improved access and a comprehensive approach to primary care, veterans' demand for VA health care should increase. If veterans' spouses (collaterals)

belong to the same plan, it greatly enhances the care for both. VA's aging population with its multiple health problems could be served better, at least initially, if both the veteran and spouse were seen on an outpatient basis or at home.

Education

NOVA endorses the Clinton proposal to increase funding for nursing education. Health care reform will require training of current and future nurses and faculty. NOVA recommends that VA continue to offer nursing scholarships and training programs for nurses. The existing programs, with time paid back to VA, is a proven model that could be enlarged to develop more nurses for expanded roles: the master prepared

advanced practitioner and the baccalaureate degree generalists preparation of RNs; the minimum level needed for content relating to patient needs in managed care practice.

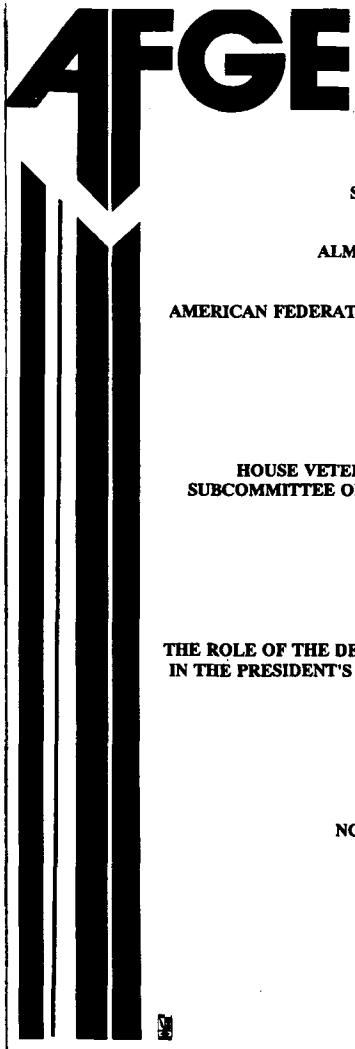
NOVA specifically supports a 10 percent distribution of Graduate Medical Education (GME) funds be pooled from all insurers and be allocated to support the education and training of primary care nurses, in a manner similar to that used in the GME program for physicians.

Funding for research and teaching must be maintained to attract staff, making it rewarding for professionals interested in pursuing these activities. Incentives, such as research, help to keep VA's affiliation with medical and nursing schools, enhancing our ability to give high quality care. This also speaks to the need to retain acute care and high technological care that cannot be obtained anywhere else. It can be concentrated in designated tertiary facilities, with training programs and teams available to other facilities.

Mr. Chairman, NOVA believes that, overall, the Administration's proposal will enable the VA to be an improved, independent health care system fulfilling its original mission of providing comprehensive health care. There is a mammoth job ahead of us which will proceed in phases. All the hopes and concerns about VA's participation in national health care reform cannot be addressed in one hearing.

NOVA is pleased to have your leadership and skills in our mutual efforts to influence progress and ensure quality health care to U.S. veterans. We look forward to working with you, now and in the future, to make the VA health care system an even better national model of health care than it is today.

Mr. Chairman, thank you for the opportunity to share with you nursing's concerns related to health care reform for the Department of Veterans Affairs. We would like to thank you for the Committee's ongoing support for nursing, and offer nursing's assistance to the Committee in the future.



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STATEMENT BY

ALMA LEE, PRESIDENT
DVA COUNCIL

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFL-CIO

BEFORE THE

HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

ON

THE ROLE OF THE DEPARTMENT OF VETERANS' AFFAIRS IN THE PRESIDENT'S NATIONAL HEALTH CARE REFORM

NOVEMBER 18, 1993

Mr. Chairman and members of the Subcommittee, my name is Alma Lee, and I am the President of the Veterans Council of the American Federation of Government Employees, AFL-CIO (AFGE). I have worked as a nurse's assistant for 27 years at the Salem, Virginia VA Medical Center. On behalf of the 125,000 employees of the Department of Veterans Affairs our union represents, I thank you for the opportunity to testify here today on the role of the VA in national health care reform.

AFGE supports the general approach to reform of our nation's health care system embodied in the President's Health Security Act. In particular, we applaud its core principles of universal coverage, progressive financing, meaningful cost-containment through global budgeting and government-coordination of the allocation of health care resources. Within this context, AFGE believes that if certain steps are taken, the VA can have an important and expanded role to play in our nation's health care delivery system.

Under the President's plan, veterans with service-connected disabilities and low-income veterans would be eligible for the standard benefit package set forth in the Health Security Act through the Department of Veterans Affairs, with no premiums, copayments or deductibles. They would be also be eligible for some other benefits not included in the standard package, such as treatment or post-traumatic stress disorder. In addition, all other veterans would become eligible to receive their health care through newly established "DVA" plans, which would compete in local alliances to provide the benefits in the standard benefits package. These veterans would participate in the plan by paying up to 20 percent of the premium charged to the alliances by the VA, with their employers paying at least 80 percent of this premium. The DVA plans would also become Medicare providers.

We believe that this plan holds great potential for the VA, because it will allow greater public access to our excellent health care facilities, but it will also put pressure on the DVA to improve conditions in many Veterans' hospitals and out-patient clinics so that they will be able to compete successfully. The stakes are high, because if the VA medical system does not succeed in the marketplace,

there is likely to be tremendous pressure to dismantle the system, sell assets to private sector providers, and reduce the government's role in providing health care to veterans' to nothing more than the provision of subsidies to private providers. AFGE believes that the latter scenario needs to be taken seriously, because we know first-hand how difficult it is to achieve change which "puts patients first" in many VA facilities.

We caution those who believe that the VA can be a successful competitor by maintaining current operating procedures. The arguments which support this position claim that the VA already has an advantage over competitors because it is accustomed to adhering to negotiated annual budgets. They believe that private sector competitors who have operated with the blank check of treating those with traditional indemnity insurance will at least take time to adapt to the reality of cost containment.

AFGE believes that this is a false and dangerous confidence. We strongly support the maintenance of a separate veterans' health care delivery system. We believe that not only do veterans deserve to have their health care needs occupy a privileged position in the nation's health care budget, but also that only a separate system will provide the specialized and often unique types of care that veterans need. But even as a separate system which has not faced full-blown competition from the private sector for patients, the VA health care system has been struggling.

The news that the President's bill originally sought $17 billion from the DVA budget as "savings" which would be used to finance other aspects of reform was quite disturbing. On the contrary, instead of cutting the VA hospital budget as part of reform, AFGE believes that in order for the DVA plans to have a fair chance to survive in competition with other providers in local alliances, the system needs extra investments initially in order for it to upgrade and modernize its facilities and address staffing shortages. Thus we support the President's new proposal to grant an additional $1 billion to be spent on VA medical facilities in 1995. We also support the notion that the VA be allowed to retain for its own budget a portion of the increased revenue it would produce through Medicare reimbursements and premiums

charged to veterans who do not currently receive care through the VA system.

AFGE has appeared before this committee repeatedly to describe the impact of budget cutting over the past decade. Staffing levels are dangerously low in many VA medical centers, and we have lacked the funding to provide adequate access to the latest medical technology for treatment and diagnosis.

The inadequate staffing levels which exist at many VA facilities are due partly to the fact that salary and benefit levels, as well as workloads, make recruitment and retention quite difficult. Nurses and other health care providers can and do receive superior compensation and working conditions at private sector facilities. Currently, the VA only competes with the private sector for staff, and despite the disadvantages I have described, overall, the quality of care in many hospitals and out-patient clinics is excellent.

I believe that when the DVA is forced to compete with the private sector for patients, pay and working conditions for nursing and support staffs will have to be improved in order to attract veterans who will be able to go elsewhere at a similar price. AFGE is hopeful that competitive pressures, along with President Clinton's reinventing government initiatives, will induce the DVA to reallocate resources to improve staffing on the level of patient care, and reduce unnecessary levels of management who are not involved in patient care. The insulation of the VA medical centers has allowed them the "luxury" of vastly bloated management ranks, and administrators who have seemed indifferent to the quality of patient care. AFGE hopes that national health care reform, in tandem with President Clinton's advocacy of a partnership approach to reinventing the way government operates, will produce revolutionary changes in labor-management relations in the DVA.

Access to Care at DVA Health Care Facilities

On the controversial issue of expanding eligibility to receive health care through the DVA plans, AFGE believes that not only previously ineligible veterans, but also the families and dependents of veterans should be able to enroll in DVA plans. We believe that it is unlikely that a veteran with a family will choose to enroll

separately, as an individual, in a DVA plan. The decision of whether to allow veterans' families and dependents to enroll in DVA plans is left to the discretion of the Secretary of the DVA in the President's plan. AFGE supports requiring the DVA, by law, to allow this expanded eligibility.

Along with the practical considerations which would make it financially disadvantageous for a veteran to enroll in a separate plan from that of his or her family, there are arguments in favor of expanded eligibility which are related directly to the quality of care available to veterans. AFGE believes that if a medical center has a more diverse case mix, the entire DVA medical system will be stronger. This is not to denigrate the value and importance of specializing in areas of particular importance to veterans, such as spinal cord injuries. But again, in order to make the DVA attractive to veterans whose medical are more general, the DVA must develop expertise in the full range of medical care.

Conclusion

AFGE believes that the President's plans for national health care reform hold the potential to improve greatly both the quality and quantity of health care services the DVA provides. The DVA will have to change its resource priorities.

TESTIMONY OF THE
AMERICAN EX-PRISONERS OF WAR

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS AFFAIRS COMMITTEE
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO
VA'S ROLE IN NATIONAL HEALTH CARE

BY
CHARLES S. PRIGMORE, Ph.D.
NATIONAL SENIOR VICE COMMANDER

ACCOMPANIED BY
WILLIAM E. BEARISTO
NATIONAL COMMANDER

WASHINGTON, DC NOVEMBER 18, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUB-COMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU TO REPRESENT THE AMERICAN EX-PRISONERS OF WAR.

THE AMERICAN EX-PRISONER OF WAR SUPPORTS THE FOLLOWING CONSIDERATION REGARDING THE VA'S ROLE IN THE NATIONAL HEALTH PLAN.

1. THE PRESENT SYSTEM OF VA HOSPITALS AND COMMUNITY FACILITIES SHOULD REMAIN INTACT, IN RECOGNITION OF THE UNIQUE HEALTH NEEDS OF VETERANS (SUCH AS EXPOSURE TO AGENT ORANGE, THE 15 PRESUMPTIONS OF EX-POWS, ETC.). VETERANS' HEALTH NEEDS REQUIRE PROGRAMS SPECIFICALLY ORIENTED TO THEIR TREATMENT. THE UNITED STATES GOVERNMENT HAS CONSISTENTLY INDICATED ITS RESPONSIBILITY FOR HEALTH CARE OF VETERANS.

2. NO FINANCING OF VETERANS HEALTH CARE SHOULD COME FROM EMPLOYERS. THIS IS PARTICULARLY TRUE OF VETERANS WITH SERVICE-CONNECTED DISABILITIES AND FORMER PRISONERS OF WAR. IT IS THE FEDERAL GOVERNMENT'S OBLIGATION TO FURNISH FREE CARE TO SERVICE-CONNECTED VETERANS AND FORMER PRISONERS OF WAR.

3. NO NON-VETERAN SHOULD RECEIVE HEALTH CARE FROM VA FACILITIES. THESE FACILITIES SHOULD REMAIN SPECIFICALLY FOR CARE OF VETERANS.

4. SERVICE-CONNECTED VETERANS AND FORMER PRISONERS OF WAR SHOULD RECEIVE A CONTINUUM OF CARE: FROM PREVENTION, OUTPATIENT CARE, HOSPITAL CARE, NURSING HOME CARE, IN-HOME CARE AND DOMICILIARY CARE, ON A BASIS OF RIGHT RATHER THAN GOVERNMENT DISCRETION.

5. VA FACILITIES SHOULD BE MORE ADEQUATELY FUNDED IN ORDER TO PROVIDE QUALITY SERVICES DISCUSSED IN (4) ABOVE.

6. WE QUESTION THE DESIRABILITY AND FEASIBILITY OF HAVING THE VA COMPETE WITH OTHER HEALTH PLANS FOR THE CARE AND TREATMENT OF VETERANS. SOME COMPETITION OCCURS NOW, AND PERHAPS ALWAYS WILL OCCUR, BUT PRESENT COMPETITION ALLOWS THE VETERAN TO SELECT ONLY EYE CARE, FOR EXAMPLE, FROM PRIVATE

HOSPITALS BUT RETAIN THE VA FOR ALL OTHER CARE. THE NATIONAL HEALTH PLAN WOULD SEEM TO FORCE THE VETERAN TO MAKE AN OVERALL CHOICE. IF THIS ONE-TIME CHOICE IS THE PLAN, WE OPPOSE IT.

THE AMERICAN EX-PRISONERS OF WAR IS DEDICATED TO A VETERANS ADMINISTRATION HEALTH CARE SYSTEM THAT IS SEPARATE AND DISTINCT FROM THE NATIONAL HEALTH CARE SYSTEM. IT SHOULD NOT BE ABSORBED IN THE NATIONAL HEALTH CARE SYSTEM. IT IS A BENEFIT THAT IS EARNED BY THE VETERAN AND SHOULD NOT BE SUBJECT TO CHOICE.

AS SENATOR ROCKEFELLER HAS RECENTLY STATED:

"ON A DAY WHEN WE HONOR OUR VETERANS FOR THE SACRIFICES THEY MADE FOR OUR COUNTRY, LET US REMEMBER OUR COMMITMENT TO THEM BY RENEWING OUR PROMISE TO PROVIDE THE HIGH QUALITY HEALTH CARE THAT THEY HAVE EARNED."

WE ARE ENCOURAGED BY SECRETARY JESSE BROWN'S PLEDGE TO KEEP QUALITY IMPROVEMENT PROGRAMS IN PLACE, AND HIS STATEMENT THAT VA CAN MAKE GOOD ON ITS CLAIM TO SERVE AS A NATIONAL MODEL OF EFFICIENCY.

WE URGE THE CONGRESS TO RETAIN THE STRENGTHS OF THE VA SYSTEM, TO PROVIDE BETTER FUNDING, AND TO MAINTAIN THE NATION'S COMMITMENT TO ITS VETERANS.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Paul S. Egan
Executive Director

To The

House Veterans' Affairs Subcommittee
on Hospitals and Health Care

On

The President's National Health Care Proposal

November 18, 1993

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Introduction

Mr. Chairman and members of the Subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to share its views on how the Department of Veterans Affairs (VA) health system will be integrated into the President's national health security plan. Thus far, we have expressed support for this plan based on briefings provided on two occasions by First Lady Hillary Rodham Clinton and on our review of the principles embodied in the overall proposal.

Fundamental Principles

As we stated in testimony before the Senate and House Veterans' Affairs Committees on April 27 and 28 of this year, there are seven principles that must be incorporated in a health plan for veterans. These principles are as follows:

* Veterans currently dependent upon VA health care, as well as those who now rely on the private sector must be permitted to exercise choice in selecting health care providers.

* VA must provide medical care of equal quality to that in the private sector; and definitions of quality must reflect user-friendliness and consumer satisfaction.

* VA must be configured in a manner such that scarce resources are husbanded properly, by realistically determining who will elect to use VA to meet health care needs.

* VA must be accurate in determining the specific investments needed in order to become attractive to current and new populations of veteran health care consumers.

* VA must be prepared to do more of what it does better than the private sector--providing care for special populations such as the spinal cord injured, blind, mentally ill, elderly and those relying on VA for prosthetics devices.

* VA must be prepared to fill a void in the nation's health care apparatus by staking out a role as a health care provider for rural communities, in order to assure a steady stream of consumers for VA's health infrastructure.

* A long term consensus must be reached in both the executive and legislative branches of government on how to fund VA health care reliably through the future.

VVA is very pleased by what we have seen of the President's health care reform proposal thus far. If this proposal becomes law, VA will be given every opportunity to "sink or swim" in a competitive environment. Veterans will be provided a choice of where to obtain care, and will have access to the full range of health services. There will be cost incentives as well as more expansive benefits package incentives for veterans to choose the VA health provider network.

We are also encouraged by some of the steps taken recently by VA to begin planning for the advent of a competitive health care arena. Secretary Brown's comments presented before both the House and Senate Veterans' Affairs Committees indicate that there is finally realization within the VA that this mammoth bureaucracy is supposed to operate <u>for</u> veteran users. We are hopeful that this watershed health reform activity will provide the impetus to improve services such that veterans <u>will</u> choose to receive care at VA.

Competition Holds Possibilities

We have identified the following components in the President's proposal which correlate closely with our proposals, and will hopefully facilitate the success of the VA health system. More importantly these points will improve upon current health services available to our nation's veterans.

The Principles:

* Veterans will have a choice of where they will receive care; either in VA or elsewhere.

* Service-disabled and low-income veterans will have access to VA care without co-payments.

* The VA will participate in national health reform as an independent health provider open to all veterans.

The Tools:

* In evaluating the policies proposed, it must be assumed that the VA health system will atrophy to non-existence with passage of national health reform unless it is able to attract veteran users by doing what it has never before been forced to do -- address user-friendliness concerns of quality and accessibility.

* The Clinton proposal gives VA a competitive edge by allowing service-disabled and low-income veterans "free" health care. In other words the premiums, co-payments and deductibles required of non-veteran citizens using the national health benefit will not be required of service-disabled and low-income veterans who choose to use the VA.

* All remaining veterans who choose to use the VA will bring revenue into the VA system -- monies from Medicare and employer insurance premiums. This revenue can expand available services within the VA.

* Additionally, "front" monies have been proposed to help VA realign itself to compete either as a national health alliance or in local health alliances.

* The plan gives the Secretary of Veterans Affairs discretion to allow veterans' dependents to enroll in the VA health alliance. Again, this would provide additional revenue to VA, while attracting veteran users who may otherwise choose non-VA health alliances in order to provide for their families.

Given the widely accepted predictions that VA stands to lose a significant percentage of its patientload when national health policy becomes law, it is obvious that this mammoth health system must improve services and erase its poor image to be an attractive health provider of choice for our nation's veterans. This will be an enormous undertaking for the Veterans Health Administration (VHA), because while some of these adaptations are very basic current medical care trends, they vary greatly from current VA practices.

A Closer Look

Defining Quality

First and foremost, VA must improve the image veteran users and non-users have of its health care quality. VA has long touted its research and training programs, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluation scores and mortality rates as evidence that it provides quality health care. None of these are measures that consumers use, however, in evaluating choices between health care providers. VA has recognized that it needs to emulate the consumer's definition of quality in order to maintain and attract veteran users. This poses an enormous challenge.

The elements of consumer quality that will have to be addressed and improved upon are: courteousness, timeliness, consistency of seeing individual physicians, minimal administrative delays, accessibility, eligibility for the full continuum of health services, and accessibility to medically appropriate care on an inpatient or outpatient basis. This will necessitate a great deal of reorganizing, retraining and general overhaul of VHA programs, in order to keep current users and attract new ones once a national health care option is available to all. The fact is that the determining factor in whether VA will survive the competition of national health reform, is how

veteran users feel about the care they receive at VA. Only when VA can accurately and demonstrably prove its health product is desirable to middle class, paying customers, will VA be prepared to compete successfully.

Primary Care Focus

A major innovation in private sector health care practices that has not been a preferred option by VA until now, is an emphasis on cost-effective primary care. This includes a reliance on outpatient over inpatient care. Private sector managed care systems have been able to reduce health care expenditures by funneling all patient health care needs through a primary care provider who then determines when more costly specialty services are required. This has been convenient and beneficial for patients aside from lower costs, as well. Their total health outlook is managed by a provider who can coordinate treatments which might otherwise overlap or counteract one another. This is particularly a problem with drug therapy for multiple conditions.

Because of the limited VA health care budget, eligibility rules were imposed to hold some veterans out of the system. Without the benefit of national health care reform, it is impossible for Congress to open VA eligibility to all veterans, or even to the full continuum of care for current users. Costs would simply be too high. Health care reform, however, will give veterans currently using or trying to access the VA, an option that doesn't exist for many now. They will be able to use their national health care benefit to get care from private health care providers. Thus eligibility reform will not swamp VHA and may not require huge additional appropriations of federal funds.

Eligibility reform accompanying national health care reform must allow VA to develop this managed care approach and practice "real medicine". By this we mean the VHA must be able to meet all of the health care needs of its patients on a medically appropriate inpatient or outpatient basis. In order to accomplish this, VHA will need to realign its resources, establishing more outpatient facilities and perhaps reducing or refocusing its inpatient capacity.

Likely Users

This realignment and resource allocation must be done with the likely users of VA care in mind. Obviously, those most likely to choose VA services under a national health plan are those that feel VA best meets their needs. VA strengths in providing prosthetics treatment, spinal cord injury care, blinded care, mental health services, care for those afflicted with PTSD, substance abuse treatment, aging conditions and long term care for the elderly will certainly come into play here. Those veterans with special service-connected conditions for which there is effectively no private sector treatment substitute available will surely choose VA care.

VA should use whatever "start up" resources are available with the national health reform package to develop its outpatient capacity, as mentioned above, to develop a rural provider network, and to build upon its most successful programs. In this way, it can best meet future demand for services, in our opinion.

Care for Women -- Both Women Veterans and Dependents

In line with this planning, VA needs to quickly advance its health care programs for women. If gender appropriate care cannot be accommodated "in-house", VA facilities must establish contract, sharing or fee-for-service arrangements. The President's health plan would give the Secretary of Veterans Affairs authority to accommodate veterans' dependents within the VA. This is an important consideration for younger veterans and women veterans.

As the VA health system faces an uncertain future in a competitive national health environment, it is vital that VA possess all tools necessary to be a quality, comprehensive provider for all veterans -- men and women. Particularly as VA will attempt to attract new, paying customers and possibly veterans' dependents, it is vital that all services available outside the VA provider network also be available within or through the VA. Unless equitable care is available for women veterans and veterans' female dependents, we are likely to see the VA health system meet its demise, as veterans choose to take their health care choices and dollars elsewhere.

Rural Provider Networks

VVA has long advocated that the Veterans Health Administration take on the mission of providing care in areas underserved by private health care providers, such as rural areas. This would be beneficial to VA for two reasons. First, ensuring a continuing demand for VA health services in rural communities would safeguard the VA's mission of providing care for veterans. Second, this would bring additional revenue to VA through regular paying customers, which in turn could be used to improve and enhance services for veterans.

There has long been concern in the organized veterans community about bringing non-veterans into the system, when many veterans are not allowed to get care. National health reform and the accompanying VA eligibility reform will make the VA open to all veterans who choose to access its services. Very often rural areas are underserved by both the VA and private sector health providers. In areas where the veteran population in itself is too small to support a facility, a VA-supported community clinic and the revenue it generates would make needed services available to both veterans and non-veterans alike. VA should embrace this mission of rural health care provider to enhance services for rural veterans.

New Funding Sources

Again, the realignment of VA under national health reform will be very beneficial for veterans because the quality and accessibility of VA and private sector health care will improve. Certainly the President's plan offers mechanisms to make these improvements through new streams of revenue to VA from Medicare, employer premiums, co-payments from non-service disabled veterans who choose a VA health provider network, as well as the possibility of payments for services provided to veterans' dependents. These funding sources can be used to improve and enhance services for veterans by making outpatient clinics more accessible, replacing outdated equipment, and a range of other service improvements.

Even if VA is competitive in attracting these paying customers, it will still be reliant on annual federal appropriations, and will continue to be vulnerable to the instability of Congressional authorizing and appropriations processes. Operational appropriations will still be required to cover the cost of providing care to service-disabled and low income veterans at a bare minimum. To assure that service-disabled veterans represent a continuing responsibility of the federal government even if appropriations are reduced and even if VA fails to successfully compete, the Congress must act now -- as part of the national health program -- to entitle service-disabled veterans to health care within and outside of VA, just as the elderly and disabled are entitled under Medicare.

Specific Language Concerns

Again, while VVA is very supportive of the key points of the President's Health Security Act, there are a few points in the language that we are concerned with and would suggest clarification and/or correction. These concerns lie with the provisions addressing eligibility for care of veterans exposed to toxic substances, radiation or environmental hazards, and the quality standards imposed on VA and non-VA facilities.

It is our understanding that veterans with service-connected conditions will be provided services beyond the standard benefits package at no cost. Under the proposed subsection 1823 (b) and subsection 1831 (a), it seems this bill would make cost-free care available to veterans who were exposed to toxic substances, radiation and environmental hazards -- but only for their exposure-related conditions unless they were affirmatively adjudicated as service disabled. If this is the intention of the legislation, this is an unacceptable method of cutting costs at the expense of veterans afflicted with often debilitating and fatal diseases. When eligibility restrictions are to be lifted under national health reform, it is unfair to impose additional financial burdens on World War II veterans exposed to radiation, Vietnam veterans exposed to Agent Orange toxins, and Persian Gulf veterans exposed to any number of environmental hazards.

Finally, the language proposed in subsection 7341 of the bill appears to give the VA a number of "escape clauses" from various federal and state regulations imposed on other health care providers. VVA has consistently advocated that VA health care should be forced to stand

up to the same scrutiny of law to which non-VA providers must comply. VA mammography equipment, for example, is not maintained at the same quality standards as that imposed on the private sector.

VVA's position on this issue is that the VA should be subject to the same quality and inspection standards as are private or public hospitals. It is our view that requiring less stringent standards of the VA does not serve its self-preservation interests as VA begins to compete for veteran patients under national health reform. How can VA attract middle class, paying customers by professing comparable quality when its facilities are evaluated by a different measuring stick? More importantly, applying lower quality standards puts veterans in second-class citizen status, as those who use the system receive substandard care.

Another National Health Issue -- Medical Liability Costs

The proposed health reform plan would also reduce medical care expenditures on diffusive medical practices by easing tort liability. While this is a necessary element to contemplate in any cost cutting measure, it is important to balance these measures with the very real threat imposed by the negligent practice of medicine. VVA advocates that the House and Senate Judiciary Committees incorporate a realistic definition of "criminal negligence in the management and practice of medicine".

One way to reduce the cost of medical malpractice insurance is to deny coverage for criminal conduct. Today the health industry is essentially exempt from criminal liability for medical "misadventures" resulting from disregard for human life and safety. In order to successfully prosecute a practitioner under criminal statutes, intent to harm must be proven. The recent case involving a Navy surgeon who was practicing at Bethesda Naval Hospital while nearly blind demonstrates the futility of current law. His conviction in lower court was overturned on appeal in the absence of proof of intent to injure his patients.

In most industries and in most circumstances where responsibility for public safety is assumed, statutory definitions of criminal conduct apply. Medical practitioners and administrators escape accountability except under tort liability. We recommend legislation to define criminality in medicine such that the definition would apply to health practitioners as well as health administrators. Our proposed definition would allow criminal prosecution of an "activity disregarding human life and safety".

In addition to providing a needed safeguard, such legislation would contribute to efforts aimed to diminish liability insurance costs. Physicians, practitioners and medical administrators could be expected to be far more careful if personally accountable for their actions or inactions, and criminally dangerous practitioners and administrators could be removed from the health system more effectively than at present.

Conclusion -- Devil in the Details

While we are convinced each of the principles VVA presented in April is met ostensibly in the President's program, it will be the Veterans' Affairs Committees and the tax writing committees, in conjunction with the Budget and Appropriations Committees who must agree on the most critical elements of a health program for veterans. After achieving consensus on principles, you and your colleagues on the Ways and Means Committee, as well as your Senate counterparts, will need to legislate these points to give practical force to the objectives. In this connection, there are two steps that must be taken.

The first step in making VA a viable health provider will be to ensure a stream of resources to the VA from individuals electing to subscribe to VA health care, who are not otherwise entitled to receive VA care without co-payments -- those who are not service-disabled and low income veterans. Again, this is apparent in the President's legislation and it is vital that such provisions are included in language at final passage.

The second of these key steps is guarantying the availability of free health care for the

service-disabled in the event that VA is unable to be sustained as an independent health provider for the nation's veterans. The Administration has done an admirable job of fashioning a program for veterans as an independent adjunct to the overall plan for the nation. In a national health environment absent the administration's plan for veterans, we are convinced the VA would become unsustainable as it is known today.

Even with the national plan and its adjunct for veterans, we are less confident than the administration in assuming veterans will subscribe to the VA as paying customers. It is precisely because VA may not succeed in becoming user-friendly and consumer oriented and thus may not succeed in attracting veteran subscribers, that we believe service-disabled veterans should be given statutory entitlement to cost-free health care just as elderly and disabled are entitled to Medicare. It is important to note that we do not ask this for all veterans; such a proposal would be cost-prohibitive. Service-disabled veterans are the men and women who have sacrificed self and safety for this nation, and their hardship should not be theirs alone to bear. Citizens of the United States owe these individuals a reciprocal commitment.

Given the Administration's confidence in VA's ability to successfully compete in a national health environment, the Administration and Congress should be willing to take the precautionary steps of entitling service-disabled veterans to the same package of no-cost health care benefits in either the VA or the private sector. If VA competes effectively enough to attract veteran users, no added costs should be expected from this provision.

If, on the other hand, VA proves unsustainable in a national health environment, the federal government must ultimately continue to accept responsibility for the health needs of those having incurred injuries or sustained diseases as a result of military services. There is no obvious way to sustain a federal responsibility short of entitlement to health care in the public or private sector once national health becomes the law of the land.

It is of utmost importance that such an entitlement be incorporated into national health care reform legislation now, rather than waiting to see what happens to VA. Anticipating continuing fiscal restraints, it is unlikely that Congress would establish a service-disabled veterans health care entitlement in five, ten or twenty years if VA disappears.

Mr. Chairman, this concludes our statement.

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001-2694 • (202) 371-8880

TESTIMONY

PRESENTED BY

THOMAS H. MILLER

FOR THE RECORD

ON BEHALF OF THE

BLINDED VETERANS ASSOCIATION

BEFORE THE

HOUSE VETERANS' AFFAIRS

SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

DECEMBER 2, 1993

CHARTERED BY THE CONGRESS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee, on behalf of the Blinded Veterans Association (BVA), I want to thank you for the invitation to participate in this important hearing. I regret however, that we were not able to appear due to scheduling conflicts but do appreciate the opportunity to submit for the record.

The membership of BVA is extremely interested in health care reform particularly as it effects the VA and is anxious to participate in the debate surrounding VAs role in national health care. Our membership tends to be more dependent upon the VA health care delivery system because of the excellent programs and services VA provides for blinded veterans. There are none finer in the world and we are determined to see they are protected and continued for our nations blinded vets. Failure to preserve the VA health care system would have devastating consequences for blinded veterans.

BVA is gratified to see President Clinton's Health Security Act does indeed preserve the VA health care delivery system as an independent system for veterans. While we are not familiar with the details of the yet to be introduced implementing legislation, we understand the VA will be required to compete with other certified accountable health care plans for the enrollment of veterans. Although we generally support the Presidents plan for VA as we understand it, we have some concerns regarding some of the funding provisions and the details of the full impact on the special disability programs such as Blind Rehabilitation.

FINANCING

Possibly the most controversial element of health care reform is financing of any plan and where the money will come from. Certainly financing is crucial if VA is to compete as an accountable health care plan. We believe VA is capable of providing comprehensive services in a managed competition environment featuring primary care as the desired delivery model. Unfortunately, VA was not and is not configured for the provision of primary care but rather acute inpatient care. Therefore, it will be absolutely necessary for VA to be given the necessary resources to update its infrastructure to be configured to better provide primary care. Additionally resources will be necessary to open Community Based Clinics to give veterans greater access to care. We believe the most important element influencing what health care plan a veteran may chose is convenience to his home unless special services are required and offered only by the VA. As the VA system is currently structured, the distances many vets live from existing VA facilities will serve as a strong deterrent to enrollment.

Essential to the Presidents plan is VA having the authority to collect from Medicare for care provided to veterans eligible for Medicare. If VA is to have a reasonable chance to attract veterans in sufficient numbers for the system to survive it must be permitted to be reimbursed by Medicare. Failure of this element to be adopted will seriously jeopardize VAs chances to compete.

Another provision, as we understand it, gives us greater concern. The provision requiring employers to contribute to the health alliance their portion of the premium for the treatment of Service Connected (SC) conditions for the VA accountable health plan is unacceptable. The financial responsibility of the federal government for the treatment of SC disabilities must not be shifted to the employers. The federal government has a moral responsibility for providing appropriate care to disabled vets and must not be permitted to transfer that responsibility. Additionally, we believe this opens the door to offsetting the appropriation for VA health care by the amount paid in premiums to the VA through the health alliances. Survival of VA health care depends on the continuation of appropriated dollars and this base must not be allowed further erosion. Many of the special disability programs and services that will be apart of the VAs comprehensive package of benefits are dependent on appropriations and without these services VA will be less competitive.

MARKETING VA

Critical to VAs survival in a competitive environment will be a highly effective marketing campaign. Essential to any successful campaign is having a quality product to market. VA must undertake an aggressive initiative to make the current system "user friendly". Waiting times, treatment of customers and basic hospital amenities currently available in the private sector must be improved to increase our marketability and competitiveness.

MANAGED CARE \ PRIMARY CARE

BVA is extremely supportive of the delivery model proposed by the Clinton Health Care Reform Plan. A managed care delivery system based on primary care is highly desirable in our view. Review of the literature and trends in health care delivery suggest this model is the most effective means of delivering quality timely services at a lower cost. Our support of this approach however is not based on any such review of the literature or trends but on practical experience found within the VA health care system itself. The Visual Impairment Services Team (VIST) program designed by VA to address the special needs of blinded veterans indeed utilizes a managed care model and has been extremely effective in providing quality services. Each year we attest to the effectiveness of this very special program by asking that additional resources be provided VA so they can provide more full time VIST coordinators to fully implement the program at more VA facilities. Without question, we believe these are the kinds of services and service delivery which blinded veterans find attractive and encourage them to enroll in VA as their accountable health plan. The availability of VIST at the local level and Blind Rehabilitation on the regional or national level makes VA very attractive and are services the private sector cannot compete with. In fact, under the universal access provision for veterans, those blinded veterans currently known as category C or discretionary, would have access to VA blind rehab and VIST and could influence them to make VA their provider.

ELIGIBILITY REFORM

While we understand the Presidents desire to hold off on eligibility reform for VA health care until the Health Security Act is adopted we believe eligibility reform should be implemented as soon as possible. We hold this view primarily for two reasons. First, with the increasing numbers of states implementing their own health care plans, VA is at a distinct competitive disadvantage under current eligibility rules. Second, health care reform could place VA in a more positive position to compete for veterans enrollment. If veterans who currently do not have access to the system had such access prior to health care reform they might be more likely to enroll if they have had positive experiences.

FAMILY PLAN

As we understand the Presidents proposal, the VA health care plan is restricted to veterans excluding their families. It does however give the Secretary of DVA the discretionary authority to include dependents of veterans. BVA has mixed feelings about this provision. We have argued in the past that the system should be for veterans only but it could be to the advantage of VA in a competitive environment to offer a family plan. Some veterans may prefer to enroll in a plan that will care for the entire family and that may be the deciding factor when making a choice of accountable health plans. It would seem logical therefore if one subscribes to this theory to have a family plan available in the beginning so as not to loose those veterans to other plans. On the other hand however we would prefer to insure that all veterans have access to the system before opening it to others such as dependents. This latter choice which Secretary Brown supports seems most reasonable in the absence of hard data to indicate failure to provide a family plan would result in the loss of significant numbers of veterans to enrollment in other plans.

PRESERVATION OF VA MISSIONS

Another extremely important reason for preserving the VA as an independent health care delivery system relates to the absolutely essential missions carried out by VA. The educational and training missions of VA are critical to the nations health care. Should the VA system fail, where and how would the education and training currently provided by VA for 50% of our nations health care professionals be obtained? VA makes a tremendous contribution in terms of providing excellent educational and training opportunities that could not be duplicated elsewhere.

VA research has also played an instrumental role in improving the health of all Americans and led to development of many state of the art prosthetic appliances. Being able to attract physicians to the VA is frequently contingent upon providing research opportunities for these physicians. In turn this enhances the quality of care provided to our veterans. Finally, who would assume the VA role as the contingency back up to DOD or in the event of a National emergency? The loss of VA beds and expertise in dealing with combat injuries would severely jeopardize the quality of care provided to any future casualties of war. Clearly, Mr. Chairman,

the VA truly is a national asset and must be preserved. This is not to say the system does not need improvement. In fact national health care reform may just provide the opportunity to reform the VA health care delivery system into a modern efficient system capable of providing high quality timely health care to more veterans than ever before.

Again Mr. Chairman, BVA appreciates this opportunity to provide our comments and views on the VA role in national health care. Although we believe VA can compete in a managed care\primary care environment, it is absolutely essential they be provided the necessary seed money and other resources to sufficiently prepare for such an environment. Restructuring and reconfiguring are certainly necessary if VA is to succeed. We also believe the authorizing and oversight functions of this committee must continue. We have grave concern over relinquishing these functions to some national board. The role of the national board regarding VA seems unclear to us but we are very reluctant to have those responsibilities assigned to such a board who has no moral obligation to our nations veterans.

We look forward to continued participation in the coming debate and development of a national plan which protects the VA health care delivery system and indeed hopefully enhances its capability to care for our nations veterans. If we can answer any questions on this issue we would be most pleased to do so.

Thomas H. Miller
Director of Governmental Relations
Blinded Veterans Association
December 2, 1993

DEPARTMENT OF VETERANS AFFAIRS
Medical and Regional Office Center
White River Junction VT 05009

December 21, 1993

In Reply Refer To: 405/11E

Hon. J. Roy Rowland
House of Representatives
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Rowland,

You have requested a statement from me for the record on those restrictions of regulation from which we need immediate relief in order to begin the process of preparing ourselves to become viable "competitors" in the evolving Health Care System.

There are those of us who will be required to react to rapidly evolving state initiatives which, if not joined by the Medical Center, may prejudice our ability to become viable competitors.

I am the Chief of Staff of the White River Junction, Vermont VA Medical and Regional Office Center. Vermont is very active in the development of a State Plan. The foundation of this Plan is to create universal access to health care for all citizens and to emphasize primary and preventative health care. According to the proposed plan, which is going through the Legislature, accountable health plans will be required to provide primary care services within 30 minutes driving distance from the home of the patient. Current VA regulations in contracting prevent us from rapidly positioning ourselves to respond to these two issues.

The single most important relief we need is the ability to encumber contractual services in a very short time frame. The current vehicle for this is Sharing Agreements for Scarce Medical Services. Under this umbrella are two distinct forms of agreement. The first is Agreements for Scarce Medical Services to be performed on VA premises (38USC7409) and so called Exchange/Mutual Use Agreements (38USC8153) for acquisition or exchange of services.

The 7409 process requires that we exhaust all means of acquiring services before using this vehicle. Because of VA Central Office (VACO) review, it takes up to 120 days or longer, once submitted, to get permission to begin the contract. We need immediate relief from these restrictions. The authority to enter into agreements must be delegated to the Hospital Director. Rigid costing requirements must be modified to reflect the "prudent business practice". As currently interpreted, ethic rules preclude any physician with a faculty title from participating in defining need for services or accessing the provision of services from the affiliated school, even though they do not receive financial supplementation from the school.

The same problems exist with 8153 Exchange/Mutual Use Agreements. We must be able to enter into primary contracts for service. For example, we must be able to contract for primary care of our entitled veteran population in those strategic locations which meet the requirements of the State Plan. The advantages of contracting are:

- Services can begin rapidly
- Broad definition of access and comprehensiveness of care can be defined (Avoids FTE limitations)
- Avoids commitment to fixed capital expense
- Maintains flexibility to change providers
- Maintains flexibility to move sites of care according to need
- Promotes Presidential and Congressional initiative to reduce Federal Employment

Another important consideration, as VHA moves into a competitive environment, is to enter the competition with a positive image. In rural states, there are natural domains for the provision of primary care with little competition. If the VA starts adding facilities and FTE to these areas, it may destabilize medical services. In many rural states there are designated underserved areas. The VA will have the opportunity to work with the communities to attract providers because of the VA needs. We can, therefore, be seen as a revenue source rather than a threat to a community. As with 7409 agreements, 8153 agreements should be totally decentralized to the Hospital Director.

If we are to compete in the new environment, we must mirror more closely the capabilities of the private sector. We may well find ourselves contracting for a host of services which cannot be classified as "Scarce Medical". For example, secretarial, engineering, grounds maintenance, etc. The ability to respond quickly is very important. For example, if support services are lost from a clinic and one needs IRM or secretarial services on contract, a contract should be possible within 24 hours. Although, one can clearly understand the overall need for government to obtain the lowest competitive price for goods and services, one has to balance this against operational needs and requirements. One cannot compete if services cannot be delivered. There are a host of issues which need to be addressed under the rubric of contracts.

The Congress should review the requirements of the Competition in Contracting Act with particular reference to the restrictions imposed in this Act which tie our hands unnecessarily. The following provisions are particularly onerous -

- Act triggers at acquisitions greater than $25,000
- 51 days are required to award a bid
- Protests are far too easy to lodge

What we are looking for is flexibility and speed. We do not object to oversight after the fact, nor do we object to being held to "prudent management standard". We are not afraid of accountability and are willing to accept the fact that some may be relieved of their jobs because they cannot do it adequately. We fear most the current inertia of the system.

Sincerely,

Howard H. Green

Howard H. Green, M.D.
Chief of Staff

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

HONORABLE MICHAEL BILIRAKIS
QUESTIONS SUBMITTED FOR THE RECORD
SECRETARY JESSE BROWN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OCTOBER 14, 1993

1) **How will the VA handle the provision of health care for "Snowbirds"?**

- VA plans will be obligated to cover the comprehensive benefits package for all enrollees. All health plans, not just VA plans, will make arrangements for services delivered to enrollees outside a plan's service area. Individuals who spend from three to six months in an alliance area that is different from the one where the individual first enrolled may choose to remain enrolled in the first plan or enroll in a plan in the new area. Several VA work groups have been established to examine and make recommendations for VA health plan management. One of the issues the group will be addressing is the most efficient way to carry out administratively VA plans for and obligations to "snowbirds".

2) **Under the Administration's Proposal, will each Health Alliance determine their own average costs?**

- Average costs are determined by the premiums charged by the health plans that choose to offer services in an area. The alliance must contract with all plans that meet State certification requirements, unless the plan's premium substantially exceeds the average premium in an alliance area.

3) **If each Health Alliance sets up their own payment schedule for services, it is conceivable that the VA could have different costs in various parts of the country. On what basis will a VAMC be reimbursed for providing services to a veteran from another Health Alliance--i.e. will the VA Medical Center treating a veteran receive the amount it costs them to provide that service or will it receive what the covering Health Alliance pays for the service?**

- VA medical facilities would establish provider agreements with other health plans to furnish services to their enrollees at reimbursement rates established in the agreement. VA medical facilities which provide care to enrollees of other health plans in the absence of a provider agreement will be reimbursed for the services according to the fee schedule that has been negotiated in the area.

4) **If a VA Medical Center treats a veteran who is a member of a different Health Alliance, will it receive the money for treating that veteran or will the money go to the Health Alliance?**

- The VA medical center would be reimbursed by the plan in which that veteran had enrolled. The medical center could be either part of a network for the veteran's plan or could be an out-of-network provider.

5) **If non-service-connected veterans will be paying different premiums for health care, will veterans across the country really be gaining equal access to VA health care under the Clinton Proposal?**

- Yes. Each veteran will have the opportunity to choose the VA plan in his or her area, and each plan will guarantee the comprehensive benefits package to all enrollees. There is nothing in the President's proposal to prohibit VA from having the same premium rate for VA health plans nationwide. However, it could be argued that allowing for different rates in different parts of the country would be more equitable than requiring veterans in low-cost areas to pay the same premium as veterans in high-cost areas pay.

6) **The VA is currently facing a tremendous backlog in needed construction projects. Under a national health care system, who will determine what construction projects are needed by the VA?**

- VA Health Plans would develop project requests as part of an overall business plan and would be expected to examine lease alternatives in the delivery of services to VA Plan enrollees. VA envisions a larger portion of services to be delivered to plan enrollees using contracted services.

7) **Currently an employer who hires a service-connected veteran who receives health care from the VA is not required to pay for that veteran's health care. Under the administration's health care plan an employer will be responsible for paying 80% of a veteran's health care premium. Do you think this will eliminate an employer's incentive to hire a veteran?**

- Under the President's proposal, employers will contribute to health insurance for all their employees. There will be no disincentive to hire veterans. With regard to whether any existing incentive would be lost, we believe that employers who currently provide health insurance to their employees generally, also provide service-connected veterans in their employ with health-care coverage. We do not believe that any significant numbers of veterans obtain employment that would not otherwise be available to them by foregoing health-insurance coverage.

8) **Under the Administration's Proposal, will the VA still be able to conduct research? If so, how will it be funded?**

- VA will continue to rely on appropriated and other (e.g., NIH grants) funds for research. The President's proposal provides support for health promotion and health services research.

9) **Since drawing non-service connected veterans into the system is essential for the effective operation of the VA health care system within the context of national health reform, how are these veterans to be encouraged to utilize VA?**

- We believe that VA plans will be an attractive enrollment choice for all veterans. VA plans will be competitive in quality of care (JCAHO scores for VA facilities average 10 points higher than comparable private sector facilities), cost, and convenience. Low-income, service connected veterans will find VA especially advantageous because they will receive their care free at VA. All veterans will continue to be eligible for current VA benefits, beyond those in the comprehensive package.

  We also believe that drawing new service-connected veterans into the VA system, through the availability of expanded outpatient services at no cost would also be advantageous to the VA system.

HONORABLE CHRISTOPHER SMITH
QUESTIONS SUBMITTED FOR THE RECORD TO
SECRETARY BROWN
DEPARTMENT OF VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OCTOBER 14, 1993

1) **The President's health plan states that all plans would receive payments from alliances based on the weighted average premium cost to that alliance to cover plan enrollees and that individuals would pay the difference out-of-pocket for plan premiums above the average cost. How does the concept of weighted average premiums work?**

- Employers contribute 80% of the weighted average premium for their employees. If an individual chooses a plan with a premium that is higher than the weighted average premium the individual pays the difference as well as the 20% family share.

2) **Based on the provision of supplemental benefits, will the VA premium be higher than other health plans? Given the fact that veterans are generally older and sicker than the general population, will veterans have to pay the difference if a VA health plan premium is above the average cost?**

- VA premiums will be competitively priced and will be based solely on providing the benefits in the comprehensive benefits package to the same extent as any other plan and not on supplemental benefits. Payments from health alliances will be risk adjusted to account for older, sicker enrollees.

3) **What happens if the VA health plan fails? Who decides if a VA health plan and its hospitals will close?**

- VA will have to carefully monitor the performance of its plans. Ultimately, the success of VA plans will be dependent on veterans choosing VA as their source of health coverage. If veterans decide that they do not wish to obtain comprehensive benefits from VA, VA may have to reexamine hospital missions. Affected Members of Congress would be consulted in such instances. If a particular plan fails, the alliance ensures that each individual is enrolled in a new plan.

4) **All plans pay a surcharge to finance a guarantee fund to assist plans in financial difficulty. Will VA ask for a supplemental appropriation for the surcharge? How will VA pay the surcharge?**

- If VA Plans are requested to pay this surcharge, the cost of that surcharge will be built into the premium rate set by the plan on the same principle as other plans operate.

5) **Will the VA be provided with the federal dollars, additional employees and general authority to expand and reconfigure its health care system so that all veterans would have equal access to VA provided benefits?**

- The President's proposal includes a VA investment fund of $3.3 billion over three years to be used to cover start up costs of VA Health Plans. The proposal also includes expanded contract and sharing authority and the authority for VA to establish alternate personnel policies and procedures. VA Health plans will need this flexibility to respond to enrollment.

6) **Since VA health care is a federal program, how will it be affected if implementation of the American Health Security Act is delegated to states?**

- VA Health Plans will be an enrollment choice for veterans through the state regional alliances. VA plans will conform to all requirements for health plans except where there is a conflict with some other Federal law or regulation with which VA must comply.

7) **Will veterans of every state have access to a VA health plan?**

- We plan to offer a VA health plan in every State.

8) **What is the time-period for enrollment?**

- Like other health plans, enrollment in VA Health Plans will be through the regional alliances The President's proposal includes a mechanism for individuals who fail to enroll in a plan during the open season to be enrolled in a plan when they seek health services. VA facilities will assist veterans to enroll in a plan.

9) **Are there any circumstances under which a core group veteran would be required to pay a copayment?**

- No

10) **How will VA provide specialty services to veterans who live outside the alliance where those services are provided, such as Spinal Cord Injury care or Blind Rehabilitation. How will these regional specialty programs coordinate access to these programs?**

- All veterans currently eligible to receive specialty services will retain their eligibility for those services. Access to special services such as these will be coordinated across alliance areas by health plan case managers.

11) **Critics of the current VA health care system point out that VA health benefits vary considerably in different parts of the country. Wouldn't the national health plan potentially result in disparities also with different VA health plans in different states or regions?**

- Since all VA plans will guarantee the same comprehensive benefits package to all enrollees, disparities across States will be greatly reduced.

12) **If a VA Medical Center becomes a member of a health alliance, to whom will that Director be accountable? To the Alliance? To VA Central Office? How will conflicts between VA's policy and leadership and the Alliance's policy and leadership be resolved?**

- The Directors will be accountable through VA line authorities to the Under Secretary for Health. Alliances will not exercise any line or managerial authority over VA managers.

13) **VA has recently formulated a draft plan of geographic boundaries which identifies 16 Veterans Service Areas (VSAs) throughout the U.S. Will these 16 VSAs be what is known as Alliances under the President's plan? Will each of these VSA's offer the full continuum of services including so-called supplemental services as recommended by the Mission Commission?**

- The VSA's will not act as alliances under the President's plan. Rather, the VSA's may be VA health plans which may in turn be certified in several States to offer services through the regional alliances established by the States. The VA will guarantee the comprehensive benefits package to all enrollees, will continue to provide supplemental services to veterans under current eligibility, and may offer supplemental services to other veterans for an additional payment from them.

14) **Since certain specialized services such as open-heart surgery would be regionalized as the Mission Commission recommended who will pay for the veteran to travel to the site of service? Will travel be covered by the premium?**

- Ambulance travel is a covered service under the comprehensive benefits package for all enrollees. Other kinds of beneficiary travel will be provided to eligible veterans enrolled in the VA plan. Costs for all covered services will be included in the premium rate. Other beneficiary travel would be covered through appropriations.

15) **The President's plan calls for alliances by state, however, the VSA's encompass many states and hundreds of miles. Conceivably will veterans have to travel further for certain services than they would if they opted for enrollment in a state alliance? What incentive is there for the higher income veterans to choose the VA plan?**

- VSA's will not act as alliances. Rather, the purpose of VSA's is to organize services for veterans most efficiently. VA health plans will be free to contract with the civilian providers to best deliver care to veterans in a particular area. Under the Health Security Act, all plans must inform potential enrollees of plan requirements and restrictions, and any other rules applicable to how the plan will manage care. All enrollees will have their choice of a health plan and accessibility to services will be a key factor in their choice. In order to ensure that VA health plans are an attractive choice for veterans, VA will have to assure that premiums are competitively priced and that services are accessible.

16) **How are veterans under this plan going to benefit from greater bureaucracy which adds an additional two layers of regulation to VA health care?**

- The President's proposal will eliminate much of the burdensome regulation that VA facilities must content with today. The Health Security Act also eliminates many of the current requirements for oversight by several review organizations (such as external peer review

organizations). VA plans to decentralize decision making and grant more autonomy for field managers to respond to local needs.

17) **Should the veteran's basic plan be more than the average citizen when we know, more often than not, veterans have special needs due to their service, such as the need for prosthetics?**

- All veterans who enroll in the VA Plan will be guaranteed the comprehensive benefits package. The comprehensive benefit package includes prosthetics, orthotics, durable medical equipment, treatment for mental illness, and a wide range of other services. VA will continue to be required to provide all services necessary such as eyeglasses, hearing aids, rehabilitation and long-term care and to provide care and treatment for service-connected disabilities.

18) **What does "guaranteed" mean? Does this guarantee differ in any way from other government guarantee programs such as Food Stamps or Home Loan?**

- All health plans will be contractually obligated to cover all services included in the comprehensive benefits. Plans will vary in how they propose to deliver the services but all plans will have to ensure timely access to all covered services for all enrollees. The term "guarantee" also serves to contrast the citizen's ability to obtain coverage under the President's plan with the hurdles that currently make it impossible for millions of Americans, including many veterans, to obtain health care.

19) **What will the functional mission of Central Office be under this plan? What will VHA's mission be?**

- The organization and functions of different VA elements may change under national health care reform. VA is currently engaged in a large-scale planning effort to address this and other organizational matters under reform. VHA will continue to perform its four missions of providing medical care, education, research and contingency back-up.

20) **When will VA develop a true business plan, the equivalent of those that VA's future competitors would present to their board of directors?**

- Work groups have examined the issues related to VA financing including the development of business plans and have provided recommendations to the Secretary. VA has begun the process of developing a corporate business plan, the first step being development of criteria. In addition, the Office of Academic Affairs is developing an education program to teach VA medical centers how to do business planning.

21) **Recent studies conducted by PVA indicate that veterans express reluctance to change providers even when offered strong incentives, such as dental or optical services, long-term care, and lower out-of-pocket costs for doing so. The Administration offers fewer incentives to veterans who may, for the first time, have the opportunity to select VA as a care provider. Is it the Administration's belief that there is a considerable "new" market of veterans who will change providers to enter VA without strong incentives to do so? On what basis?**

- Veterans may not have to change providers if they choose the VA Health Plan. VA Health Plans will be establishing a network of community providers to ensure timely and convenient access to services for all enrollees. The Health Security Act also requires all health plans to allow enrollees full choice of health care providers even outside of networks established by plans. We believe the VA Health Plans will be an attractive enrollment choice for veterans, especially those who have service-connected disabilities or low income, or who are ex-POWs, and thus will pay nothing -- no premium, no copayments, and no deductibles -- for the comprehensive package if they choose VA.

22) **In order for VA to become user-friendly and attractive to potential subscribers, VA employees must become more customer oriented. Will VA ask Congress for legislation enabling VA to more easily dismiss and replace employees who are discourteous, incompetent or otherwise unwilling to provide the kind of care environment expected by paying customers?**

- We strongly agree that VA needs to become more responsive to customer needs. Thus, to help provide VA with the tools it needs to be more responsive and competitive, the Health Security Act includes authority for VA to establish alternative personnel rules and policies for VA Health Plans.

23) **Assuming that decisions on competitiveness will need to be made on the local level, what sorts of changes are contemplated to remove layers of bureaucracy and give local managers decision-making authority?**

- Work groups have been established to address these and other issues regarding VA organization and management under national health care reform. Recommendations will be submitted to the Secretary from the work groups in the near future. No decisions have yet been made.

24) **If VA fails to attract sufficient numbers of veteran subscribers, what will the Administration be prepared to propose for service-connected and low-income veterans if VA health care disappears?**

- We believe that the VA Health Plan will be an attractive choice for veterans, and that it is premature to discuss proposals based on the assumption that VA will not be a viable choice for veterans. In any event, VA will retain its responsibilities under current law to provide care and treatment to these and other veterans.

25) **Will the current restrictions on contracting authority be lifted? What limitations will be in place to prevent VA from privatization?**

- The Health Security Act expands the VA's current contracting and sharing authority. This new authority will allow VA Plans to set up effective provider networks to ensure that all enrollees have timely access to needed covered services.

26) **In those areas where no VA plan is offered or readily accessible, where will the service-connected disabled veteran or the low-income veteran receive care?**

- VA Health Plans will be offered in all regional alliances as an enrollment choice for all veterans. VA may start new staff based services in areas to meet demand or may set up a delivery system which includes a network of providers.

27) **How can VA improve and compete if it goes into debt? Will VA be able borrow funds for capital improvements, start-up costs, etc.? Isn't it true that the impact of this plan is to shift responsibility for financing VA care from federally appropriated dollars to the private sector?**

- VA will not be going into debt. The Health Security Act includes $3.3 billion over a three-year period to provide start up funding for VA Health Plans. VA will be dependent upon federally appropriated dollars to cover a wide range of costs, such as all of the costs associated with providing services such as long term care and readjustment counseling which are unique benefits for eligible veterans and the veterans' share of the costs of service-connected and low-income veterans who choose the VA Plan. The new sources of funding under the Health Security Act, e.g. premium payment from employers and Medicare payments, will help strengthen the VA health care system.

28) **Will VA be requesting startup costs from the Administration to cover the costs of the severe equipment backlog and construction deficiencies?**

- The Health Security Act includes $3.3 billion to cover start up costs for VA Health Plans. New equipment and construction may be included in these start up infrastructure improvements.

29) **Is the total cost of administrative functions going to go down or up under this plan?**

- We expect that administrative costs will decrease with more decentralization of decision making and standardization of data collection and billing forms.

30) **In order to implement this plan isn't it true that VA must have accurate cost per patient data? Given its past track record, when will VA be able to provide such data and prove its accuracy?**

- While useful for VA internal management purposes, it is not necessary to have detailed costs per patient data to develop guidelines for a VA health plan operation and for premium rate setting. VA will begin installing a new management information system in the hospitals this summer.

31) **How and when will VA be able to develop a billing process similar to that of the private sector?**

- VA has a billing system and process in place that is comparable to that used by the private sector and is collecting about half a billion dollars each year through billings.

32) **How long a transition period would the VA be allowed before it must participate in the national health plan, and what are the estimated funding requirements for the VA to make the changes necessary to play its envisioned role in the National Plan?**

- The Health Security Act requires all states to implement its provisions by 1998. VA would follow the same time table. Funding of $3.3 billion is included in the Act to cover start up costs for VA plans.

33) **How would VA construction programs be funded?**

- VA medical construction would continue to be funded through appropriations. However, some capital costs, including construction, should be included in the premium rates set for VA health plans. Thus, premium payments to VA may help to meet VA construction needs.

34) **Since under this plan health services will be determined by the National Health Board, does Congress lose the ability to determine veterans health benefits?**

- No. The Health Security Act itself, not the National Health Board, determines the content of the comprehensive benefits package. In addition, Congress retains control over it. Many services, such as readjustment counseling and long term mental health services, for veterans who are eligible for that are not included in the President's comprehensive benefits package under national health reform.

35) **Does Congress still maintain control over the pay-scale of VA employees? If so, what effect will this have on VA's ability to compete for health professionals?**

- The Health Security Act will give the Secretary of Veterans Affairs authority to establish alternative personnel policies and procedures. This possibly may include alternative pay scales for employees of VA health plans. We believe that this issue of pay scales is an extremely important one to the ability of a VA health plan to be competitive.

36) **Does Congress still maintain control over VA construction and research?**

- Yes.

37) **What responsibilities will Congress have over VA health care?**

- Congress will continue to have a role in appropriations, authorizations and oversight of VA activities. VA health plans will adhere to most of the guidelines and oversight established by the National Health Board; however, VA missions are much broader than providing only the comprehensive benefits package to enrollees and Congress is expected to continue to be actively involved in overall operation and policy for the system as a whole.

38) **What will happen to Congressionally-mandated staffing requirements and minimum bed requirements?**

- If staffing and bed requirements continue to be imposed on the VA system, they would make it more difficult for the VA to be competitive. These staffing and bed requirements should be lifted to enable VA to compete effectively under health care reform.

39) **Is VA going to have a separate research account? If not, how will VA pay for part-time doctors/researchers?**

- VA will continue to be dependent on appropriations and other funds (e.g., NIH grants) for research.

40) **Will veterans have to pay for VA to provide DoD back-up in the form of increased premiums? Shouldn't DoD pay the annual cost of maintaining that capability?**

- VA will include in the methodology for setting premiums costs associated with VA plans providing covered comprehensive benefits to enrollees on the same basis as other health plans. Costs that are associated with support of VA missions that are unique to the VA, such as DoD contingency costs, will continue to be supported through appropriations. These costs will not be included in premium rates for VA Plans.

41) **Please provide a detailed list of all the services covered under the basic benefits package? The Committee would also like to see a list of the supplemental benefits which may also be included in the VA health plan.**

- Services covered under the basic benefits package are described in Title 1, Subtitle B, Part 2 of the Health Security Act. Supplemental benefits which the VA may provide include

such services as long term nursing care, long term mental health services, adult dental care, eyeglasses and hearing aids, domiciliary care, and home improvements and structural alterations.

42) **The proposal states that VA facilities will be able to retain cost-sharing paid to VA by individuals or employers as well as revenue obtained as reimbursement by third-party payers. At the same time, the plan indicates that "Federal appropriations for the VA health care system cover actual costs of delivering the comprehensive benefit package for which the VA health plan is not reimbursed by other sources of revenue. Does such an arrangement actually provide additional revenue for the VA system, or merely provide new sources of revenue substituting existing appropriations and maintaining the funding status quo? Should the appropriations portion be capitated mandatory funding?**

- This arrangement provides additional funding to the extent that appropriations are not adequate to provide care to veterans for whom care appropriations are made.

43) **Does this additional source of funding create a disincentive for treating service-connected and low-income veterans whose care would be covered by shrinking appropriations while favoring care for higher-income veterans who would bring premiums and copayments with them to the system?**

- No. To the contrary, the Health Security Act creates strong incentives for service-connected and low-income veterans to select the VA. VA will also receive payments from regional alliances for all enrollees including service-connected and low-income veterans.

44) **Please provide the number of self-employed veterans. What will be the estimated revenue loss if self-employed veterans are reimbursed by the Alliances?**

- VA has no information on the number of service-connected self-employed veterans who would elect enrollment in a VA health plans.

HONORABLE CHRISTOPHER SMITH
QUESTIONS SUBMITTED FOR THE RECORD TO
DR. JUDITH FEDER
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OCTOBER 14, 1993

1) **The plan states that access for all citizens to affordable health care is ensured. What about geographic access? Will veterans be ensured geographic accessibility to health care?**

- All individuals will be able to choose among the health plans offered by the alliance. They may consider location and accessibility of providers in selecting a health plan.

2) **The President's plan states that "financing would come from a multitude of funding sources." To what degree will this "multitude of funding sources" dilute the federal responsibility?**

- Federal responsibility will remain for full funding of services to service-connected veterans and low-income veterans that are not covered by premium payments from regional alliances for comprehensive benefits and for all other supplemental services such as long term nursing care, long term mental health services, readjustment counseling, dental care and domiciliary care. Appropriations would continue to support the VA education, research and emergency contingency missions.

3) **OMB has been one of the biggest barriers to VA's economic operations for years, how will these barriers be lifted?**

- VA operation of health plans should make the Department less dependent on the Budget process because additional funding sources would be available to VA from premium payments from regional health alliances for each enrollee in a VA plan. The President's plan will provide VA with greater fiscal stability.

4) **The plan states that VA will "modify financial processes to allow adjustment to resources quickly and easily to meet plan needs." How will financial processes be modified?**

- Establishment of a revolving fund for VA health plans will result in more flexibility and greater ability to respond quickly to meet plan needs. A VA work group has been established to make recommendations on plan financial management.

5) **How can you insure that these financial system changes will not result in a decrease in the provision of quality services and an increase in waiting times, etc.?**

- All health plans will have to ensure timely access to appropriate services for all enrollees. VA will have to meet these same criteria. VA plans may make use of expanded contracting arrangements and establish broad community provider networks.

6) **What happens if at the end of a 4th quarter of a fiscal year VA finds itself short of funding?**

- VA plans will have to be managed effectively and premium rates set at amounts sufficient to ensure adequate funding to allow plans to cover the comprehensive benefit package for all enrollees.

7) **Would appropriations for VA health care be mandatory or discretionary? Would veterans' health care become an entitlement program or would it remain as is?**

- The VA health system would continue to operate as a discretionary program. However, VA health plans would be obligated to cover the comprehensive benefits package for all enrollees.

8) Does "independent" mean that VA will continue without oversight from non-VA entities?

- VA now is subjected to voluntary oversight by many non-VA accrediting entities, such as JCAHO, and would continue to participate in these kinds of reviews. VA health plans will be required to meet State certification requirements except to the extent that those requirements conflict with applicable Federal regulations. How VA will manage and operate its health plan and health system will be an independent function of the Department.

9) Does this plan put HHS in charge of VA? Why or why not?

- HHS will not be in charge of VA. The VA will independently operate and manage its health plans and health care facilities.

10) Will the infusion of Medicare dollars realistically contribute to capital costs and infrastructure changes? Won't Medicare reimbursement simply cover the cost of individual episodes of care? If so, there is no "new" infusion of dollars -- at best, it will be a wash --payment rendered for services incurred.

- Medicare reimbursements will represent a new source of revenue for VA since VA receives limited reimbursement for these services now. The President's proposal includes $3.3 billion to assist VA in making infrastructure improvements associated with start-up costs for VA health plans.

11) For some time, VA has been collecting third-party reimbursement from private insurance companies for the care of all veterans receiving VA health care with the exception of service-connected disabilities or diseases. Is it consistent to limit Medicare reimbursement for VA services provided only to non-core high-income veterans?

- VA collecting from third-party payers is not a relevant precedent because VA has not been retaining third-party reimbursements for use in providing health care services to veterans. Therefore, it is not inconsistent with current law for Medicare reimbursements to be limited to non service-connected, high-income veterans.

HONORABLE TIM HUTCHINSON
QUESTIONS SUBMITTED FOR THE RECORD TO
SECRETARY JESSE BROWN
DEPARTMENT OF VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OCTOBER 14, 1993

1) **Won't the state-by-state coverage result in different coverage for veterans given the lack of uniformity of services from state to state?**

- No. All health plans, including VA Plans, will provide the same comprehensive benefits package nationwide.

2) **Based on the provision of supplemental benefits, will the VA premium be higher than other health plans?**

- The premium rate for VA Health Plan would be competitively priced. Current supplemental benefits for service-connected and low-income veterans will continue to be funded by appropriations and will not be included in the basic comprehensive benefits package offered by VA Health Plan.

3) **Since the VA will be under oversight of the NHB, how can it be called "independent"?**

- The President's plan calls for the NHB to set certain guidelines applicable to all health plans concerning general issues such as quality parameters and covered benefits. The NHB does not prescribe how plans should operate or be managed. VA will not be under the control of the NHB anymore than companies such as Blue Cross or Kaiser Permanents will be.

4) **Will the National Board set VA policies and guidelines?**

- The NHB would set only general guidelines applicable to all health plans. VA will be developing its own policies and procedures to operate a VA Health Plan and to ensure continuous provision of services to eligible veterans.

5) **Does the term "independent" include any degree of exclusivity for veterans? The plan states that "VA facilities serve as providers to other plans.", do we conclude that the term "independent" does not include exclusivity of the system for veterans?**

- Only veterans and their dependents would be able to enroll in VA Health Plans. VA facilities may sell excess capacity to other plans and providers if the Secretary approves that policy. The VA now has more than a thousand of such sharing agreements with non-VA facilities.

6) **Will the VA continue to have a separate budget or will it be part of the global budget for health care?**

- VA will continue to have its own separate budget.

7) **What happens to hospitals who do not meet the criteria for inclusion in a health alliance?**

- VA envisions all of its hospitals qualifying as providers to VA Health Plans.

8) **If a VA hospital is unable to compete, who has the authority to modify its mission or close it?**

- The Department will continue to have the authority that it does today to manage VA facilities.

9) **Do the pregnancy-related services include abortion?**

- The pregnancy related services include abortion services that are determined by a doctor to be medically necessary or appropriate.

10) **Will abortions be performed in VA hospitals?**

- All health plans will offer the services in the comprehensive benefit package if they are medically necessary or appropriate. A health professional or provider that is opposed to performing a particular service on moral or religious grounds may refuse to do so.

11) **If the NHB establishes the benefits package, would the VA, if it wished to change the package, be able to? If not, how can it be called independent?**

- Although VA Health Plans would be required to offer the comprehensive benefits package established under the Health Security Act, VA health care system, however, can provide additional and supplemental services to eligible veterans. In addition, VA will continue to have health care responsibilities and authorities beyond the range of services required by the benefits package. For example, VA will continue to be responsible for long-term and rehabilitative care for service-connected disabilities beyond any limits in the benefits package and to provide readjustment counseling services. Operations of VA Health Plans and facilities will be independent.

12) **The Secretary said that self-employed disabled veterans would have to pay for their health care and later be reimbursed. Why go through the bureaucratic process of payment and reimbursement? Why charge them in the first place?**

- Reimbursement to service-connected veterans choosing the VA Health Plan is, we believe, the simplest administrative procedure since it would involve only VA procedures and not require coordination of information, exceptions to procedures, and other elaborate checks between VA and state regional alliances. It also allows veterans a mechanism to choose other health plans besides VA if they wish to do so.

13) **How much will it cost to bring VA hospitals up to a level to be competitive with other health plans?**

- With the $3.3 billion that the President's proposal makes available over three years to be used to fund start-up costs of VA Health Plans including improving VA infrastructure, we believe VA will be able to compete successfully.

Questions submitted for the Record by the Honorable J. Roy Rowland
Subcommittee on Hospitals and Health Care Hearing
November 18, 1993
Responses of Thomas L. Garthwaite, MD, President, National Association of VA Chiefs of Staff and Chief of Staff, VA Medical Center, Milwaukee, WI

1. You expressed concern that an era of managed competition would create some additional tensions between VA medical centers and affiliated medical schools, but suggested that there are compelling forces which drive the two together. Would you expand on the tensions you foresee and any potential problem areas of which Congress should be particularly attentive as it works on health care reform legislation?

The major tension is financial competition. Veterans who are given a choice of accountable health plans could choose either the VA plan or the medical school plan. Many medical schools have a direct financial interest in a university hospital and all have an interest in faculty practice plans. Advertisement and marketing of these competing plans could cause VA and affiliated medical schools to try to exploit each other's weaknesses to attract enrollees. The relative success of one entity could mean relative failure of the other.

If a spirit of cooperation is maintained, there are potential cooperative ventures which could benefit both VA and the medical school. Combined programs in highly specialized areas will be cost efficient and allow both VA and the medical school plans to compete successfully. VA could provide services for the school plan and vice versa. There is also an enormous untapped potential for VA and the academic medical centers to consolidate overhead. For example, we could combine quality assessment mechanisms for JCAHO, share billing systems, consolidate purchasing, combine training, and share specialty expertise in area such as radiopharmaceuticals, specialized laboratory testing, and radiation safety. As a result, both VA and its affiliate's plans would be more competitive than they would be without cooperation. Flexibility in contracting would be necessary.

Other important forces which balance the competition for patient revenues are the common missions of education and research. It will be important to maintain funding for those two mission in VHA to maintain the affiliations and to continue the cooperative spirit which exists today. VA provides an intricate infrastructure for education which includes a rich patient base, resident training slots, clinical research funding, and outstanding faculty. A disruption of this infrastructure would be disastrous for both the quantity and quality of graduate medical education in VA and the country as a whole.

2. You expressed a concern in your testimony regarding the as yet undefined methodology for adjusting payments to health plans based on risk, in view of the fact that veterans who receive care from VA today are more likely than the general population to suffer from multiple chronic diseases, mental illness, HIV infection, and poverty. Under the proposed Health Security Act, an independent national health board would be charged (among other functions) to develop a risk adjustment methodology, taking into account demographic characteristics, health status, geographic area of residence, socio-economic status, the proportion of enrollees who are SSI and AFDC recipients, and any other factors determined to be material. The bill would also direct the board to give "consideration" in developing the methodology to "the unique problems of adjusting payments to health plans with respect to individuals with mental illness". (A copy of the pertinent pages of the bill are enclosed.) Insofar as the bill specifically recognizes SSI beneficiary recipients, for example, who like SSI recipients are impoverished and totally disabled, should be specifically identified in these provisions as well? Have you any specific recommendations for further amending the bill's risk adjustment provisions to address the concern expressed in your testimony?

Accurate risk adjustment for the entire population will not be easy since accurate data regarding current health status is often lacking or fragmented. Patients with certain diagnoses can be predicted to use more resources than those without these diseases (alcohol and drug addiction, chronic mental illness, AIDS, cancer, chronic pulmonary disease, tuberculosis, severe vascular disease, and many others). In addition, other factors such as compliance, financial incentive of illness (to maintain disability payments), smoking, educability, nutrition, and genetics play major roles in predicting the need for health care resource consumption.

If a health plan's enrollees are a random sample from the entire population, there should not be any harm to the plan for taking care of its share of high resource consumers. However, if a particular plan has already attracted a highly skewed sample from the population (e.g. the VA population is based on known disability or poverty), the risk for that plan could be great.

A veteran's status as recipients of SSI or veteran disability payments may capture a portion of the health status of the individual. However, the health status should also be based on objective, measurable criteria. These might include such parameters as serum creatinine, cardiac output, type of cancer, x-ray findings, HIV status, and specific diagnoses (e.g. leukemia, cirrhosis, Crohn's disease, Alzheimer's disease, schizophrenia).

3. Would you expand on your testimony regarding the need to change VA's "culture"? Where does one begin, and to what extent is local autonomy a key component?

There are many principles and habits which comprise the VA's culture which can be changed. Included below are a few examples.

Reward patient service not service to the bureaucracy: Clinic secretaries who are exceptional at welcoming patients and supporting the clinic have only one way to advance from their entry level job, leave the clinic and work as a manager or as a secretary to an administrator or service chief. We should remove the incentive to leave patient care for those good at it and create an incentive for the brightest and friendliest to seek such jobs.

Substitute education for inspection: In a time when marketing may be a key to survival, VA is faced with an effective antimarketing tool: over inspection. There is an overwhelming sense in the field that inspections are rarely cost effective and usually have a punitive intent. Inspections which find nothing are rarely reported. Inspectors do not examine whether it is possible to meet criteria with the resources available. Finally, there is no credentialing and privileging process for inspectors. We assure that our professionals are trained and competent in their area of practice and must not demand less from those who inspect us.

We should define achievable curricula, test understanding and outcome, and report the results whether good or bad. High achievement or need for improvement could be shown. Inspectors should function at a level of understanding which allows them to teach as they inspect. The process can aid in quality improvement if properly designed. In addition, we should review the credentials of all inspectors prior to allowing them to inspect our medical centers.

Trust employees rather than immobilize them with rules: Government has a need to try to prevent the next random or sporadic bad outcome. Usually the response is to make a rule forbidding that such a random event will ever happen again. Having a rule against such a sporadic event does not prevent it, rather, the rules overwhelm and paralyze the employees. Eventually, the organization becomes rule bound. The very rules which were designed to help become the cause of the next failures. We should attempt to streamline the guidance we give to our employees and trust them to carry out the mission. The job of Congress and VA leadership is to facilitate and support their efforts.

Balance expectations with possibilities: We are asked to provide first rate health care. Yet, we are not allowed to pay competitive rates to the community unless we can document suffering first (ie. to get comparability pay we must have lost employees and had difficulty in hiring). These kind of rules absolutely predict and determine that in these areas we will become mediocre at best. The basic forces at work predict the outcome. We should maintain comparability with the local pay structure (or slightly exceed it if we really want to excel).

Provide incentives for desired outcomes: We have very little flexibility in providing incentive pay for productivity. The need is especially critical in physician special pay where we reward longevity and full time status but not hard work or quality. We should design the system to reward what we say we want.

Information systems have become essential clinical tools: For some strange reason, computers have become a dirty word in health care funding for VA. Perhaps, there is an impression that dollars spent on computers cannot be spent on health care for veterans. There does not seem to be a similar argument for dollars spent on CT scanners or ultrasound machines. We need to shift the thinking from computers as manager's toys to computers as critical instruments for patient care. Whether this is a culture shift for VA or Congress, I am not sure. I am sure that computers will be the "stethoscope of the 90's" and that our current computers have improved both the quality and quantity of care for veterans.

Organizational performance is dependent on individual employees: If we want our organization to get an A, we need employees who can achieve an A in their performance. If we cannot remove or reassign those with C's and D's, how can we collectively achieve an A. With education and good management, an employee might move up a grade or even two. But if we cannot move D's down to their proper rung on the ladder where they can achieve at an A level, we cannot get our organization to where we all want it to be. Human resource regulations should facilitate the process.

4. The medical marketplace is changing and will change further, with or without enactment of sweeping health care reform. I infer from your testimony that you see a need to "reinvent VA" and have more local autonomy even if health care reform is not enacted. Do you see a need for legislation to accomplish those goals, and, if so, of what nature?

As a VA "Reinvention Laboratory," our VA Medical Center is actively engaged in trying to explore the boundaries which hamper us from achieving our goals. Many of the limitations are within the medical center or Department. The major areas of legislative concern include decentralized contracting authority, relief from FTEE ceilings and floors, eligibility reform, incentive pay, and ability to survey customers.

5. You spoke about the importance of local autonomy. Within the budget constraints you face, what kind of action would you consider taking at your facility to serve patients better if you and the director were granted relative autonomy?

Examples of area where local autonomy would allow better decision making and more effective use of resources:

- more liberal use of incentive pay
- comparability pay without having to endure gaps in employment
- decrease the number of inspectors and credential all inspectors prior to inspections
- hire off OPM lists
- retain all, or a portion, of MCCR collections
- minimize actions which require VACO approval
- move fiscal resources as needed between capital expenditures and personnel
- change method of paying physicians to reflect quality and productivity
- spend project and equipment money as needed rather than at end of fiscal year
- adequately fund education for employees
- remove ADP limitations
- eliminate FTEE floors and ceilings
- expand flexibility to contract for services

6. Your testimony cites the importance of local autonomy as a principle which should guide VA in an era of health care reform. That principle has force in the context of VA operating successfully in an environment of managed competition vis-a-vis delivery of a standard benefits package. Some would view adherence to local autonomy as placing at risk important VA programs which are not covered or only partially covered under the standard package such as nursing home care, blind rehabilitation, PTSD care, and other mental health services. How does one harmonize the need for relative local autonomy with what might be seen as an equally compelling need to protect potentially vulnerable programs which offer supplementary benefits?

Autonomy does not necessarily mean complete freedom to do anything a medical center wants to do. We must provide a standard of care in all areas of medicine. Many special programs were set up to develop systems of care (as research or pilot studies) in areas which are frequently unfunded by private insurance. Rather than continue these programs indefinitely, we need to assess whether these programs are cost effective and beneficial. If they are of benefit, we need to communicate that to the payers of care. It is up to the payers to purchase those benefits.

7. The Secretary has stated emphatically that VA will provide care for dependents through contract arrangements. Could this limitation affect VA's ability to compete effectively with other health plans?

The VA should use appropriated funds only for veterans. If dependents with non-appropriated fund come to a VA accountable health plan and we have space available, we should be able to treat them. I believe the inclusion of dependents will balance the loss of veterans who opt for non-VA plans. Additionally, the addition of dependents would allow VA to offer services which otherwise would not have enough patient load to be cost effective (eg. women's health care).

Questions submitted for the Record by the Honorable Christopher H. Smith
Subcommittee on Hospitals and Health Care Hearing
November 18, 1993
Responses of Thomas L. Garthwaite, MD, President, National Association of VA Chiefs of Staff and Chief of Staff, VA Medical Center, Milwaukee, WI

1. Is a proven effective quality management system essential to VA's competitiveness in a national health care reform scenario?

Our quality management system should be as good or better than the competition's. I believe it is.

2. The mission commission envisioned VA making the transition from a system of episodic services to a continuum of services. Do you believe the president's health plan is a vehicle for such a transition?

With or without reform of the system of paying for health care (such as the Clinton plan), VA and non-VA systems should move toward coordination of care. I believe the Clinton plan does promote a continuum of services in that it provides preventive medicine services in the basic plan. The plan also is a risk-adjusted, capitated plan which therefore provides a financial incentive to provide effective preventive and restorative services (e.g. treating hypertension rather than its complications).

3. The mission commission stated that "the care of the older veteran population requires substantial commitment to long-term care." Do you believe the health security act makes such a commitment to the provision of long-term care?

I have not become an expert on the health security act, but I do not believe that any plan will tackle long-term care comprehensively. I believe that American's are not ready to hear the bad news regarding long-term care: you cannot have your loved ones live in a nursing home for several years and get the inheritance. We still want to have both and we look to government to pay for nursing home stay.

4. The mission commission recommended substantial redistribution of resources to match the migration of veterans. Does the health security act allow for such redistribution?

The key to redistribution of resources are clear rules on eligibility and accurate, risk adjusted payments based on workload.

5. Do you believe VA has developed a quality management system, a cost accounting system, and a resource allocation methodology comparable to that of the private sector?

For health care delivery, I believe our quality management systems are better that those in the private sector (JCAHO scores suggest the same). Cost accounting is not great anywhere but ours lags behind since we have only begun to bill for services. I have not been a supporter of our resource allocation models because they have not allowed us to compare our funding to that in the private sector. Some studies suggest we are 20% underfunded compared to the private sector for the work we accomplish. Certainly, many of the criticisms of VA could be corrected if our budget were increased by 15% (and we would still be a bargain).

6. If the President's plan was passed, should each VA medical center director be responsible for defining the mission of his or her facility? Do you believe this local autonomy should occur regardless of passage of the President's plan?

I do not believe in individual missions. I think there should be a corporate vision. The autonomy should be in making management decisions to accomplish the local contribution to the national missions.

7. Do you believe VA's current medical model is based on disability and disease or is it based on a wellness model? Should this change? If so, how?

I believe we do both (ie. we treat acute illness and promote wellness). Perhaps, at times, we are guilty of concentrating on the patients in our emergency rooms with chest pain rather than educating our younger veterans on the evils of cigarettes and diets high in saturated fats. Society and health care organizations should move to early detection and intervention for smoking, alcohol, drugs, exercise, seatbelts, dangerous behaviors, handguns, and environmental hazards.

8. In your opinion, is the VA's current system of centralized management an inhibitor or a facilitator to the President's health care plan?

The current system of management for VA will inhibit the success of many medical centers under the Clinton plan because it adds layers of overhead costs and slows response to market forces.

9. What is your opinion on the VA's recently formulated draft plan to establish 16 veterans service areas?

Moving decisions and support closer to the point of patient contact makes some sense. There are several questions to be answered before one can predict that likelihood of success. Is the role of the VSA to be a master to be served or a servant of the providers of care? When will VA decide on a structure and allow it to mature enough to be effective? Can any organization which changes its structure every couple of years be expected to work? Can congressmen allow mission changes in "their" VA medical centers?

10. What effect will the President's health care plan have on VA research?

Increased pressures to spend more time delivering clinical care rather than performing research studies may have detrimental effects on research. Without research (and the academic teaching environment), there is no way to maintain our high quality care at the current level of reimbursement.

11. What are the disincentives to VA's competitiveness? What has to change?

The following are some of the impediments to VA competitiveness:

- image
- geographic access to care
- insufficient reimbursement for work performed
- too many inspections
- old physical plants
- restrictive personnel regulations
- few incentives
- culture inhibits change and innovation

All the above must change.

12. Do you think the President's reform proposal is too wide sweeping? Would you favor a more incremental approach to health care reform?

Big problems require bold solutions. At the time, the institution of DRG's by HCFA was considered bold. In retrospect, DRG's are believed to have slowed the rise of medical costs. Since managed competition has not been thoroughly tested, its effect on U.S. health care remains unknown.

I support universal coverage, preventive focus, tort reform, reduced administrative costs, and appropriateness of all treatment modalities. The easiest, cheapest and probably the most effective single thing government could do for health care is to support and lead the standardization of medical information storage and transfer. The computerized medical record will ultimately help control medical costs, reduce administrative waste, improve quality, and make rational decision making possible.

13. Your testimony states that one option of reform is to allow VA to provide such specialized services in which it has developed special expertise. Do you believe inclusion of such services is essential to VA's ability to survive in a competitive scenario?

While inclusion of such services may not be essential, it would be expensive to revamp many of our medical center's missions. It would also be unwise not to exploit one's strength.

National Association of VA Physicians and Dentists
Responses to Questions from November 18, 1993 Hearing

Questions from the Honorable J. Roy Rowland

1. In your opinion, can VA compete if it does not provide care in-house to both veterans and their dependents?

NAVAPD believes that the VA Health Care system is a national resource which should be an integral part of any national health care system. Although its primary reason for being is and should be the care of those who have served their country in this nation's wars, the system is also a resource for the nation. It delivers care more cost effectively than the health care system at large and has made significant contributions to medical research and training. To compete in a national healthcare system, the VA must upgrade equipment and physical surroundings. Medical Centers must have the flexibility to serve the markets in which they operate with the specialties to which they have already committed resources. Although veterans should come first, underutilization can affect patient care, so it is in the interests of veterans and the nation to be sure that the VAMCs are operating at levels that allow them to provide comprehensive and quality patient care. Therefore, we believe Medical Centers that are underutilized by veterans should be permitted to serve other needs of the community such as veteran dependents and military personnel and to negotiate sharing agreements as necessary to maintain an efficient and effective hospital. As a first step in rationalizing the use of VAMCs for veterans, we strongly support a simplification of eligibility requirements that would allow doctors to treat the patients who come to the VAMCs based on their medical and dental needs rather than the complex set of regulations and restrictions we now face.

2. Should VA be concerned about its ability to compete for certain physicians and other health professionals under health reform? What problems will VA face?

Yes, the VA will have problems competing for certain physicians, dentists and health professionals as the system is presently designed. It is difficult to comment on specific specialties since we have not yet seen a design for the VA system under health care reform. As an example, most analyses point toward a greater requirement for primary care physicians and dentists within the VA and throughout the system. If demand increases in the private sector and VA compensation is not competitive, we could have difficulty recruiting an adequate number of primary care physicians to fill our needs. But compensation is not the only issue. The total work environment must be considered. VA physicians and dentists are highly trained, respected professionals, many of whom also are affiliated with prestigious medical schools. A recent NAVAPD survey showed that 91 percent of the survey respondents (almost 15 percent of all VA physicians and dentists) said that "improving patient care" remains the top priority of the medical professionals in the VA system. In contrast, only 65 percent of the respondents placed "immediate pay increases" as a top priority. While care of the patient remains the top priority, physicians and dentists must face the reality of economics. Despite efforts in the past decade for more equitable pay, VA physicians and dentists remain far below their private sector colleagues on the pay scale. Recent denial of the locality pay that was designed to make the U.S. government more competitive with the private sector has created an inequity that will severely affect the morale of VA physicians and dentists at the very time when recruitment and retention of high quality doctors is necessary to the future of the VA system if it is to compete under health care reform. Efforts must be made to address the inequities between the VA and private sector pay scale. If the system is to compete for patients it may not be able to depend on finding doctors who are willing to sacrifice their compensation potential in order serve the VA, particularly if the environment in the system continues to deteriorate and they feel there is a lack of respect for their efforts from the administration.

3. Dr. Garthwaite testified about the need to change VA's "culture". Do you agree with his assessment?

If the VA is to compete in the future, it must rid itself of the bureaucracies that clog and distort the decision making process. It must improve the management process and increase the flexibility and rationality of resource allocation within hospitals and within the system. The eligibility system must be rationalized to permit doctors to make decisions regarding the treatment of patients based on their medical and dental needs rather than a complex set of regulations and restrictions. In general, more responsibility and the attendant accountability for patient care must move to the physicians' and dentists' level for these are the providers directly concerned with the patient's welfare. It is important that the VA build on the strengths of the system. VA physicians and dentists must be provided with the resources necessary to treat their patients and be held accountable for the care that they provide. More flexibility is needed for the physicians and dentists to determine what is necessary to provide the highest quality health care to their patients. (See also Rowland Questions 4 and 5)

4. **Substantial restructuring and change are already occurring within the private medical sector. Given that pattern, should this committee give consideration to legislation -- to permit more flexible hiring practices, for example -- that would enable VA to begin to position itself as well?**

NAVAPD believes the House Committee on Veterans' Affairs and its Subcommittee on Hospitals and Health Care should take action quickly to enable the VA Medical System to prepare to compete in a national healthcare system. (See also Rowland Questions 3 and 5)

5. **Do you share the views of other witnesses who see a need for greater autonomy at the VA medical center level?**

Steps must be taken to increase the flexibility and rationality of resource allocation within hospitals. We support the principle of reimbursement based upon services provided, just as in the private sector and that resources be equitably and rationally distributed, based upon productivity and quality of service. VA physicians fear that managed care means simply, more of the same management and less care. We don't need more overhead. We are aware that VA Central Office is beginning a process of reorganization that is designed to address these problems. But we are concerned because the bureaucracy that breeds favoritism and inequity is deeply entrenched. Without a solution to this difficult problem, we do not believe the VA System can compete. (See Rowland Questions 3 and 4)

Questions from the Honorable Chris Smith

1. **Does the VA have in place any incentive system to reward staff for achievements based on productivity and timeliness of services rendered?**

No. The most appropriate incentive system should be based on giving physicians and dentists the means for providing the best possible care in each situation. It should be designed to reward those who provide the most efficient and highest quality care with greater resources to provide that care. In other words, if a department shows that it is serving a larger number of patients with efficient and quality care and therefore, in a competitive environment, bringing more revenue to the hospital, that division and the doctors in it should have a greater proportion of the funds returned to that department to upgrade equipment, and make other improvements that will further increase efficiency. Other factors that would help motivate and retain high quality doctors is a more rational pay system and adequate funding of VA research and development, which has proven to make a direct contribution to recruitment and productivity.

2. **Do you agree that VA needs to become more customer-oriented? Would you support legislative authority which would make it easier for VA to dismiss career employees who do not put the customer first?**

Yes. The VA must rid itself of the institutional mindset that has bred bureaucracies that clog and distort the decision making process. Physicians and dentists must have adequate resources and flexibility to provide the best possible care to patients and must be accountable for the care that they provide. (See also Rowland Question #3)

3. **Are VA employees encouraged to participate in setting quality standards for patient care?**

There is a great deal of lip service paid to improving quality standards in the VA system and an enormous amount of time spent on "quality" programs. But these are too often bureaucratic exercises that make no contribution to real improvements in the quality of patient care. Quality is undermined by the way the system works: The eligibility system, the irrational distribution of resources, the top heavy administration. VA physicians and dentists, who work with the patients are dedicated to quality of patient care and should be an integral part of defining and setting quality standards in regard to the care of their patients care. The VA bureaucracy sometimes makes this impossible.

4. **The Mission Commission stated that "high quality patient care requires that VA develop and uphold defensible standards. Accountability must permeate every level of the organization with emphasis on innovative delivery of services at the patient-care level." Is this true of the current VA health care delivery system? If not, how do you suggest VA meet this recommendation?**

In private sector hospitals, physicians and dentists hold the major responsibility for the quality of care their patients receive. They also are held completely and ultimately responsible for efficiency and process of delivery of that care. This should be the case in the VA Health System, but it is too often overridden by the centralized management that is in existence at the VAMCs. The first concern of the physicians and dentists of the VA is the quality of the care they deliver to their patients. Studies by the General Accounting Office have shown that patient care is provided at significantly lower cost in the VA Medical System when compared to the private sector. In addition, evidence of the System's success is seen in a recent survey that NAVAPD itself conducted as a means of assuring that our objectives and goals were truly representative of VA physicians and dentists. Overwhelmingly, this survey showed that "improving patient care" remains the top priority of the medical professionals in the VA system. Administrative personnel have other concerns than the quality of patient care and, sometimes, other considerations than the most efficient delivery of care. We feel strongly that both quality and innovation of delivery would improve if more responsibility and accountability were put in the hands of the doctors who care for the patients. VA doctors would be motivated to increase efficiency and innovation, if they knew that they had some control over their individual department. As is the situation at private sector hospitals, doctors that treat more patients more successfully than others -- the department should be awarded a greater percentage of the resources available whether from appropriations or reimbursement funds. That department should have first priority on new equipment and other resources that will allow the doctors there to treat more patients more efficiently. If autonomy and resources were permitted at this level there would be an immediate improvement in efficiency and patient care.

Marvin Dunn, M.D., dean, University of South Florida College of Medicine
Representing the Association of American Medical Colleges

Responses to questions submitted in writing
after the House Veterans Affairs' Subcommittee
on Hospitals and Health Care hearing
November 18, 1993

Questions Submitted for the Record by the Honorable J. Roy Rowland

Question #1--In responding to a question about medical school programs in rural areas where there is not an affiliation with a VA medical center, you testified to the fact that many of your colleagues across the country are developing rural health initiatives which could include veteran patients if there existed "cooperative alliances." Could you explain this concept in more depth? The Committee would also welcome more information on the specific rural health initiatives to which you referred. To the extent you are able, could you advise the Committee of any instances in which the schools have attempted to work with VA medical facilities to include veteran patients in development of such initiatives, and of the status of such efforts?

I believe cooperation between VA medical centers and other providers, including medical schools and teaching hospitals, is essential to the continued viability of the VA and the maintenance of the first-rate medical care that veterans have been promised. One example of the "cooperative alliance" to which I alluded would be an arrangement under which VA medical centers entered into agreements with area health education centers (AHECs), which provide medical-care and health-education services to underserved communities, as well as educational opportunities for health professions students and residents. The University of South Florida set up an AHEC program with state support. We will carry out a great deal of primary-care education at these AHEC sites. By arranging for AHECs and VA medical centers to work together, we could offer even more training in primary care to students and residents and deliver more care, particularly to veterans in underserved areas.

For more information on medical schools' efforts to address rural-health problems, I have enclosed "Academic Initiatives to Address Physician Supply in Rural Areas of the United States," a compendium prepared in 1991 by the AAMC.

Question #2--In the context of testifying to your experience in Florida regarding joint planning for the allocation of residency positions, you expressed concern that if the VA were to become "separated off the reallocation of residency slots, we will all lose." Would you please expand on this concern?

VA currently participates as an integral partner in academic residency-training programs all across the country. VA funds a resident's salary and benefits for the portion of time spent at the VA medical center. Each year VA supports over 8,500 positions, through which over 31,000 residents rotate. This historic and successful integration benefits both the academic medical centers, the VA hospitals, and veteran patients. Any centralized federal plan to allocate positions needs to be supportive of this historic relationship.

Question #3--The President's proposed Health Security Act appears to place the allocation of residency positions in the Department of Health and Human Services under a National Council on Graduate Medical Education. Can this Committee be confident about the stability and viability of VA's longstanding role in graduate medical education under this proposed new mechanism? Would you concur that VA, under any national health reform including one based on the proposed Health Security Act, should continue to receive separate funding (through VA appropriations) to support graduate medical education programs? Does it make sense to apply rigidly to VA the ratio of primary care/specialty positions such as that set forth in title III of the Act, when the nature of VA's patient population is such that VA would not provide certain primary care services (such as pediatric and obstetrical care)? Should VA either be excepted from such fixed ratio requirements or be considered, for purposes of such ratio, as part of a network of institutions with which it may be associated?

Under the model of a National Council on Graduate Medical Education, it is not clear what the stability or viability of any given residency program would be. It does not make sense to apply a rigid ratio of primary-care-to-specialty-care positions to VA-supported resident positions alone, especially since VA does not provide family practice, pediatrics, or ob/gyn resident positions, but does support a large number of residency positions in COGME-designated shortage specialties such as psychiatry and general surgery. It would make sense for VA to participate broadly with other educational partners in local consortia which meet 50:50 quotas and to be considered as part of such a network of institutions.

VA should continue to maintain its separate appropriation to fund residency positions in its health-care network. In this way it can contribute needed funds to support approved residency positions in local consortia and assure that these residents will rotate through VA.

Question #4--The Secretary has stated emphatically that VA will provide care for dependents through contract arrangements. Could this limitation affect VA's ability to compete effectively with other health plans?

A stipulation that the VA may only provide care for dependents through contract arrangements could adversely affect the VA's competitiveness if caring for dependents would be more cost-effective within individual VA facilities. VA medical centers need to have the flexibility to care for dependents, or contract for their care, based on an assessment of the individual medical center's resources and capability. Caring for dependents within VA facilities may very well be appropriate if no veterans are denied services by dependent care and if veterans will not utilize the VA without the opportunity to have their dependents' care overseen by the same health professionals in the same facilities.

Questions Submitted for the Record by the Honorable Chris Smith

Question #1--Is a proven effective quality management system essential to VA's competitiveness in a national health care reform scenario?

Quality-management systems are essential to the competitiveness of all providers. The VA has been out in front of many of its non-federal colleagues on this issue by instigating total quality improvement (TQI) efforts in fiscal year 1991. The VA's peer-review and JCAHO scores, moreover, have been comparable to non-federal hospitals, another sign that quality management efforts at the VA have had a demonstrable effect.

Question #2--The mission commission envisioned VA making the transition from a system of episodic services to a continuum of services. Do you believe the president's health plan is a vehicle for such a transition?

The Clinton plan could be a vehicle for transforming VA health care from an episodic basis to a continuum of services. The VA must, however, enhance its primary-care services to expand the range of its health-care offerings. Congress can help as well by reforming eligibility statutes to allow veterans to receive a reasonable range and continuum of services from VA medical centers and clinics, and by providing the VA with the funds and flexibility to create and staff more outpatient clinics.

Question #3--The mission commission stated that "the care of the older veteran population requires substantial commitment to long-term care." Do you believe the health security act makes such a commitment to the provision of long-term care?

The Health Security Act allows the gradual phasing-in of long-term care benefits. With the aging of the general population, long-term care will take on added importance across the country. The VA has already begun emphasing long-term care and geriatric services, and is ahead of many non-federal facilities and programs in this arena. Furthermore, long-term-care services may be more accessible to veterans that choose to receive health care from the VA than to those veterans outside the VA system.

Question #4--The mission commission recommended substantial redistribution of resources to match the migration of veterans. Does the health security act allow for such redistribution?

Under the health-alliance system proposed by the Health Security Act, a citizen's premium would be remitted to the alliance. This would mean that resources would move with the veteran if the veteran relocates, resulting in an effective geographic resource allocation of health-care service dollars. VA staff and equipment, under such a scenario, would "follow the dollars." However, many areas receiving influxes of veterans do not currently have the VA facilities necessary to serve the newcomers adequately. An investment in infrastructure in several areas of the country will be necessary to provide capacity for this migration of potential VA facility users.

Question #5--Do you believe VA has developed a quality management system, a cost accounting system, and a resource allocation methodology comparable to that of the private sector?

As I mentioned earlier, the VA's quality-management system, based empirically on the VA's peer-review and JCAHO scores, seems to be effective. I do not believe I can comment on the VA's cost-accounting system or resource-allocation methodology at this time, since my contact with the VA is mainly on the clinical level.

Question #6--If the president's plan was passed, should each VA medical center director be responsible for defining the mission of his or her facility? Do you believe this local autonomy should occur regardless of passage of the president's plan?

Local autonomy should be encouraged within certain guidelines determined by the VA and by Congress. In any case, a VA medical center's mission should and must be driven by the needs of its veteran patient population.

Question #7--Do you believe VA's current medical model is based on disability and disease or is it based on a wellness model? Should this change? If so, how?

The VA, along with the vast majority of its non-federal colleagues, is moving toward a wellness-based model. Health-care reform and eligibility reform would be additional stimuli in this direction. Allowing dependents to receive care in VA facilities may contribute to the overall wellness of veterans and their dependents through family services such as nutritional advice, mental-health support, and smoking-cessation classes, to name three possibilities.

Question #8--In your opinion, is the VA's current system of centralized management an inhibitor or a facilitator to the president's health care plan?

I believe the VA will have to adjust and decentralize to meet the demands placed upon it by health-care reform, and will have to rationalize its delivery system to conform to the changed world in which it operates. I have no doubt that the VA's organizational and management structure will undergo some alteration as a result of health-care reform. The VA must move toward a system that empowers medical-center directors with the ability to respond to patient needs.

Question #9--What is your opinion of the VA's recently formulated draft plan to establish 16 veterans service areas?

Although I have not had an opportunity to review the VA's plan in detail, I believe that the proposal would offer greater flexibility at the local level, which, as I mentioned earlier, should be encouraged within general guidelines.

Question #10--What effect will the president's health care plan have on VA research?

Although the Health Security Act does not address VA medical and prosthetic research, I believe the continued viability of VA research is essential to the maintenance of innovative and outstanding medical care at VA facilities. The House Veterans' Affairs Committee has worked tirelessly to remind appropriators of the importance of VA research, and my colleagues and I greatly appreciate this support. With a bleak outlook forecast for VA health research and other domestic discretionary programs over the next few years, VA research will continue to need the committee's support to ensure the stability of the program.

ACADEMIC INITIATIVES TO ADDRESS PHYSICIAN SUPPLY IN RURAL AREAS OF THE UNITED STATES

A COMPENDIUM

MARY LITTLEMEYER & DEBBIE MARTIN

Address all correspondence concerning "*Academic Initiatives to Address Physician Supply in Rural Areas of the United States: A Compendium, 1991*" to Mary H. Littlemeyer, AAMC, 2450 "N" Street, N.W., Washington, D.C. 20037-1126.

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PREFACE

This compendium contains descriptions of 250 initiatives from 65 educational institutions that are addressing the problem of physician supply in the rural United States. This publication supplements "Academic Initiatives to Address Physician Supply in Rural Areas of the United States: A Select Bibliography, 1980-1990," published in December 1990 (Rural Health: A Challenge for Medical Education—Proceedings of the 1990 Invitational Symposium, *Acad. Med.* Vol. 65, No. 12, Supplement 1990, S55-S84). The abstracts and annotations that follow represent activities in 40 states and the District of Columbia. Our request for program descriptions was directed to informed individuals in the field we thought most likely to possess details of these activities: 126 U.S. medical school deans, 10 directors of offices of rural health, and 133 Area Health Education Center (AHEC) directors, as well as others who attended the AAMC-W.K. Kellogg Foundation-sponsored 1990 invitational symposium on rural health held in San Antonio. Respondents were helpful and prompt in providing descriptions from unpublished sources and citations to the literature.

In the pursuit of these data we learned of a similar undertaking by the Working Group of Teachers of Rural Family Medicine of the Society of Teachers of Family Medicine. Appendix 1 is based on information from that study, which was obtained from chairmen of departments of family medicine in U.S. medical schools and from program directors of family practice residencies in the United States. While a review of this appendix reveals some repetition of information appearing in the AAMC compendium, a considerable amount of new information is also found.

ACKNOWLEDGMENTS

The Association of American Medical Colleges expresses appreciation to The W. K. Kellogg Foundation and to Contract # HRSA 91-973(P) with the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, for the financial support that made this publication possible.

We are particularly indebted to those who provided information on which this compendium is based: Deans of U.S. Medical Schools; Directors, Offices of Rural Health; and Directors, Area Health Education Centers (AHECs). During the summer they sent program descriptions or bibliographic citations to us for the compendium. They then approved the abstracted material and consented to have their names and addresses published so that readers could obtain additional information from them. Finally, we contacted some contributors whose programs were proposed or pending near press time to ascertain their status. Contributors were responsive and generous with their time in these several stages of this production.

For the cooperation and contribution of Thomas E. Norris, M.D., Director, Tacoma Family Medicine, Family Practice Residency, and Richard G. Blondell, M.D., University of Louisville Department of Family Practice, Co-Chairmen of the Working Group of Teachers of Rural Family Medicine of the Society of Teachers of Family Medicine we are most appreciative. Appendix 1 is based on data they collected from Directors of Departments of Family Medicine of U.S. medical schools and from Directors of Programs of Family Medicine. Charles G. Huntington, M.P.H., Assistant Director of the American Academy of Family Physicians' Washington Office, was especially helpful in facilitating our use of the AAFP project findings.

GUIDE TO THE USE OF THIS DOCUMENT

Pages 1-44 contain descriptions of educational initiatives in U.S. medical schools addressing the problem of physician supply in the rural United States. These are arranged alphabetically by state name. Those wishing to obtain additional information should refer to the source line that introduces each description. Readers are reminded that this compendium is an extension of the annotated bibliography published in December 1990. Programs established since then comprise this compendium; programs previously described (December 1990) are included here only if they have been modified. In both publications additional information is available from individuals shown as contacts or sources.

In Appendix 1 (pages 45-53) programs reported in April 1991 in a study conducted by the Working Group of Teachers of Rural Family Medicine of the Society of Teachers of Family Medicine are outlined. This appendix is also organized by state name.

RELATED READINGS

1. **Rural Health: A Challenge for Medical Education—Proceedings of the 1990 AAMC-W K Kellogg Invitational Symposium.** *Academic Medicine*, Volume 65, No. 12, Supplement 1990.

This 140-page issue of *Academic Medicine* contains "Academic Initiatives to Address Physician Supply in Rural Areas of the United States: A Select Bibliography, 1980-1990," with abstracts and annotations by Mary H. Littlemeyer and Debbie Martin.

Among papers by over 15 distinguished authors in this volume is one by Eugene S. Mayer, M.D., M.P.H., Academic Support for Rural Practice: The Role of Area Health Education Centers in the School of Medicine. Dr. Mayer is Project Director of the North Carolina AHEC.

This issue of *Academic Medicine* is available from AAMC Membership and Publications Office, 2450 "N" Street, N.W., Washington, D.C. 20037-1126. Item Number **65DS**, $25.00 plus $6.00 handling. Allow 3 to 4 weeks for delivery.

2. **20th Anniversary of the National AHEC System: Projects in Review.** *National AHEC Bulletin (Special Edition)*. Fall, 1990. (48 pp.)

This issue includes a report from each of the 32 active AHEC programs in the nation with a brief history and a summary of activities and future plans. It provides a picture of the national project in 1990, 20 years after the idea was advanced in the October 1970 Carnegie Commission Report on Higher Education to "distribute health care personnel and training facilities more equitably with particular emphasis on rural and urban medically underserved areas."

Available from AHEC Project Officer in your state or Ms. Cherry Yuriko Tsutsumida, M.P.H., Chief, Multidisciplinary Centers for Programs Branch, Division of Medicine, BHPr, HRSA, PHS, DHHS, Room 4C-05, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. (301) 443-6950.

ABSTRACTS AND ANNOTATIONS

ACADEMIC INITIATIVES/ REPORTS FROM THE INSTITUTIONS

ALABAMA

Source: William B. Deal, M.D., Associate Dean, University of Alabama at Birmingham School of Medicine, UAB Station, Birmingham, Alabama 35294

The **University of Alabama School of Medicine (UASOM) in Huntsville's** five-week Junior Family Medicine Clerkship has been described. [*Acad. Med.* 65(December Supplement 1990):S57-S58]. Similar programs are located at the **UASOM in Tuscaloosa** and at the **Birmingham** campuses.

A six-week Family Medicine/ Community Medicine Clerkship is required for junior medical students at the Tuscaloosa campus. Following an orientation by faculty from the Departments of Family Medicine and of Behavioral and Community Medicine, the student spends five weeks in one-to-one learning under the supervision of a community family practitioner. The strategic position held by the family physician as the physician of first contact and the importance of community resources are underscored.

The Tuscaloosa program also offers a five-week Community Medicine Clerkship elective for senior medical students. The student participates in the practice of a community physician, providing care for individual patients under the physician's supervision. Ways in which the physician becomes concerned with the total health and health-related needs of his or her patients, their families, and the community as a whole are examined, and the student becomes aware of the opportunities for the practice of preventive medicine and health promotion in the community.

Source: Jim L. Wilson, M.D., Professor and Chairman, Department of Family Practice, University of South Alabama, 1504 Springhill Avenue, Mobile, Alabama 36604

The **University of South Alabama (USA)-Mobile** currently has the following programs whose focus is to increase rural physician supply:

1. The Family Practice Residency program is designed to improve and strengthen the curriculum so that residents completing their training will be more likely to locate in rural or urban underserved areas.

2. An extensive network of rural family physician preceptors is maintained for a required third-year, six-week rural preceptorship rotation and fourth-year elective rotations.

3. Funds from the Alabama Family Practice Rural Health Board were awarded to the Department of Family Practice to consolidate some of its off-campus clinical experiences for medical students and residents through designation of five Rural Community Family Practice Teaching Site areas to be developed over three years beginning with 1991. The objective of this program is to enable the faculty of the Department of Family Practice to strengthen its ability to recruit students and residents from rural areas and to interest them in returning to similar areas once their training is completed.

4. Another program for medical student recruitment relationships has been established with seven colleges from which the medical school would like to recruit at least two students a year.

5. Among continuing education programs are the following: (1) over 100 Grand Rounds in rural areas are conducted weekly by the USA-Mobile faculty upon request of rural physicians; and (2) mini residencies are available for rural physicians.

ARIZONA

Source: Andrew W. Nichols, M.D., M.P.H., Director, Rural Health Office, University of Arizona Health Sciences Center, 3131 East Second Street, Tucson, Arizona 85716

Research, service, and education at the **University of Arizona Rural Health Office** have been described [*Acad. Med.* 65(December Supplement 1990):S58-S59]. Twenty-seven monographs have been produced by staff of UA's Southwest Border Rural Health Research Center:

(1) Alcantar, E., and LaBrec, P. *Health Issues Along the Arizona-Sonora Border*, Oct 1988; (2) Estrada, A. L., *Socioeconomic and Health Status Indicators Among Elderly Mexican Americans in the Southwest*, Dec 1988; (3) Estrada, A. L., *Utilization Barriers Among Mexican Americans in the Southwest*, Dec 1988; (4) Estrada, A. L., *Barriers to Utilization of Health Services Among Mexican Americans in Arizona*, Jan 1989; (5) Gordon, R. J. *The Effects of Malpractice Insurance on Certified Nurse-Midwives: The Case of Rural Arizona*, Jan 1989; (6) Nichols, A. W., *AIDS Along the U.S.-Mexico Border*, Jan 1989; (7) Estrada, A. L., Erickson, J.R., Stevens, S. J., and Glider, P. J., *Risk Reduction Among Hispanic IV Drug Users and Receptivity to Community AIDS Education*, Oct 1989; (8) Gallagher, K. *Use of Prenatal Services: Special Population Needs Assessment*, Nov 1989; (9) Gordon, R. J., Higgins, B. A., and Walters, J. B. *Declining Availability of Physician Obstetric Service in Rural Arizona and Medical Malpractice Issues*, Dec 1989; (10) Lopes, P. M., Nichols, A. W. *Community Financed and Operated Health Services: The Case of the Ajo-Lukeville Health Service District*, Mar 1990; (11) Gallagher, K., and Gordon, I. G. *Study of the Availability of Obstetrical and Other Primary Care Services in Underserved Arizona*, Mar 1990; (12) Estrada, A. L. *AIDS Knowledge, Attitudes and Beliefs Among Blacks, Hispanics and Native Americans in Arizona*, June 1990; (13) Erickson, J. R., Estrada, A. L., and Stevens, S. J. *AIDS Risk Reduction in the Criminal Justice System*, June 1990; (14) Lopes, P. M. *Primary Care Via a Mobile Health Unit: A Case From Rural Arizona*, July 1990; (15) Lopes, P. M., and Nichols, A. W. *Special Tax Supported Ambulatory Care Health Districts*, Aug 1990; (16) LaBrec, P. A. *Utilization of Yuma Regional Medical Center by Mexican Nationals*, Sept 1990; (17) Estrada, A. L., Erickson, J. R., and Stevens, S. J. *AIDS Risk Behaviors Native American IVDU's: A Preliminary Report*, Oct 1990; (18) Erickson, J. R., Estrada, A. L., and Stevens, S. J. *Risk for AIDS Among Female Sexual Partners of Intravenous Drug Users (IVDU's)*, Oct 1990; (19) Estrada, A. L., Erickson, J. R., Stevens, S. J., and Glider, P. J. *HIV Risk Behaviors Among Mexican-Origin and Anglo Female Intravenous Drug Users: A Comparative Analysis*, Oct 1990; (20) Erickson, J. R., Estrada, A. L., Stevens, S. J., and Glider, P. J. *Development and Testing of Instruments Indexing Variables in a Model of Prevention for AIDS*, Nov 1990; (21) Warrick, L. H., Wood, A. H., Meister, J. S., and de Zapien, J. G. *Evaluation of a Peer Health Worker Prenatal Outreach and Education Program for Hispanic Farmworker Families*, Dec 1990; (22) Meister, J. S., Warrick, L. H., de Zapien, J. G., and Wood, A. H. *Un Comienzo Sano: A Case Study of a Community-Based Prenatal Intervention*, Dec 1990; (23) Nichols, A. W., LaBrec, P. A., Homedes, N., Geller, S. E., and Estrada, A. L. *Utilization of Health Services Along the U.S.-Mexico Border*, Dec 1990; (24) Estrada, A. L., Hughes, A. *Hispanic Health Care Needs Along the*

United States/Mexico Border and the Training Needs of Health Providers, Dec 1990; (25) Lopes, P. M. *Health Services in the Copper Basin: What is Needed? What is Wanted? What is Affordable?* Dec 1990; (26) Lopes, P. M. *Arizona Rural Hospital Chartbook*, Jan 1991; (27) Gordon, I., Erickson, J. R., Mahmoud, H. *A Comparison of Rural and Urban Certified Nurse Midwives in Arizona*, Jan 1991.

ARKANSAS

Source: Charles O. Cranford, D.D.S., Executive Director, Area Health Education Centers Program, University of Arkansas for Medical Sciences, 4301 W. Markham, Slot 599, Little Rock, Arkansas 72205

In 1990 the **University of Arkansas for Medical Sciences (UAMS)** established the Delta Health Education Training Center (Delta HETC) to provide education and training to health sciences students, medical residents, and health care practitioners for the improvement of health care along the Mississippi River. Among the goals of this program are increasing recruitment and retention of primary health professionals in the Delta through increased health career education, rural training experiences for health profession students, and continuing education and professional support services for practicing providers.

In 1991, UAMS established the Center for Rural Health. The Center expands rural health initiatives of the University by creating the Rural Hospital Program and a new focus on rural health services research. The Rural Hospital Program will demonstrate the strengthening of rural hospitals through clinical and educational affiliations with various components of the university. Rural health services research will emphasize the public policy implications of unmet rural health needs.

Source: Lee B. Parker, M.D., Director, AHEC-NW, University of Arkansas for Medical Sciences, 241 W. Spring Street, Fayetteville, Arkansas 72701

The 1991 legislature voted to increase its financial loan forgiveness program for **University of Arkansas** medical students returning to rural areas to practice up to over $50,000 over a five-year period.

Four-week rural practice preceptorships are offered to freshmen and sophomore medical students. Stipends for housing and other living expenses have been increased to $300/ week.

Source: Geoffrey Goldsmith, M.D., M.P.H., Garnett Professor and Chairman, Department of Family Medicine, University of Arkansas for Medical Sciences, 4301 W. Markham, Mail Slot 530, Little Rock, Arkansas 72205-9985

The **University of Arkansas for Medical Sciences at Little Rock** Department of Family and Community Medicine is developing a rural health care track for its residents. One of the first new educational activities in this rural track is a rural family practice elective rotation. The entire residency curriculum is being reviewed to identify how to tailor the three-year residency to the future needs of a rural physician.

In association with the statewide AHEC, a required, decentralized family practice clerkship was initiated July, 1991.

This clerkship allows students to gain educational experiences in smaller communities throughout Arkansas.

An occupational medicine fellowship was developed by the Department of Family and Community Medicine and the Department of Toxicology and Pharmacology. One area of concentration is in agricultural medicine.

CALIFORNIA

Source: Gessert, Charles, et al. Family Physicians for Underserved Areas—The Role of Residency Training. *West. J. Med.* 150(Feb 1989):226-230.

University of California San Francisco School of Medicine graduates of four rural and four urban family practice programs were interviewed to determine the nature of their practices and the factors that had influenced their practice location decisions. All programs gave residents substantial experience providing continuity of care for underserved populations. Of the 158 physicians surveyed, 58 were working in areas designated as underserved. The percentage of physicians in underserved areas was higher than that reported in other studies and was much higher than would be expected if practice sites were selected on the basis of population distribution alone. Notable differences in personal and practice characteristics were found between the physicians who chose to work in underserved areas and those who did not and between those who established practices in rural and in urban underserved areas.

Source: Marita Grudzen, Division of Family and Community Medicine, Department of Medicine, Stanford University School of Medicine, 703 Welch Road, Suite G-1, Palo Alto, California 94304-1760

Stanford University School of Medicine's Rural Health Course, offered through the Division of Family and Community Medicine, combines field experience with a series of seminars about issues and models of health care. In the Rural Health Course medical students visit several rural areas in Northern California and observe many rural health problems. Through discussions with health care providers and with people involved with the agricultural industry, they gain an appreciation for the complexity of the issues that only direct experience can give. Topics such as migrant working conditions, accessibility of health care, and appropriate levels of technology arise naturally during the field trip. Ethical and policy questions related to these topics are also addressed.

Source: Watts, Malcolm S. M., and Clark Jones. *The Story of the California AHEC System: California Area Health Education Centers: 1972—1989.* Fresno, CA: California AHEC System, 1990. 200 pp.

This 16-year history of the **California Area Health Education Center (AHEC)** program concludes with a forecast of its future. It chronicles the experience of cooperative educational programming among the eight medical schools in the state, and between the medical schools and 18 target communities, aimed at improving the distribution of health professionals and access to health care.

This report traces the activities of a project that was awarded more than $54 million in federal AHEC funds over a 16-year period. It lists large numbers of significant achievements such as 48 new, enlarged, or enhanced medical residency training programs; 177 new primary care residency slots; 152 hospitals and other libraries linked into 12 consortia to support medical practice and education

in rural areas; 51 hospitals and clinics organized into nine self-supporting, continuing education consortia; 9,400 student-weeks of clinical education for medical students per year in AHEC-sponsored programs at peak; over 60,000 minority students given orientation into health careers; over 8,400 minority students enrolled in courses and clubs to strengthen their academic preparation and creation of a national model for Hispanic medical education.

COLORADO

Source: Curtis Stine, M.D., Associate Director for Medicine SEARCH, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Denver, Colorado 80262

The Statewide Education Activities for Rural **Colorado's Health (SEARCH) AHEC** program is designed to improve the maldistribution of health providers in Colorado (1) by attracting new physicians to less populated areas by giving students and residents educational experience in rural Colorado and (2) by retaining the providers already practicing through accessible continuing education and consultation to rural communities.

Many of the school's courses offer students opportunities for rotations in Colorado communities. These courses range from first- and second-year electives to third-year core clerkships (medicine, pediatrics, psychiatry, and surgery), as well as senior electives and the required family medicine and primary care clerkships. Sites for many elective courses are also available in many communities throughout Colorado. The SEARCH program reimburses student expenses, including round-trip mileage and housing. Several AHEC sites maintain student apartments.

D.C. DISTRICT OF COLUMBIA

Source: Pauline Y. Titus-Dillon, M.D., Associate Dean for Academic Affairs, Howard University, College of Medicine, Washington, D.C. 20059

Howard University College of Medicine's four-week Senior Medical Preceptorship elective exposes students to different primary care settings. In the Urban Preceptorship students work with a primary care physician in a private office setting, community health clinic, or hospital emergency room. In the Rural Preceptorship students work with family physicians in rural private offices or in community health clinics. Students are assigned to preceptors who are expected to orient them to office procedures and management. Students are involved in home visits, hospital rounds, medical meetings, and other practice-related activities.

FLORIDA

Source: J. Ocie Harris, M.D., Professor of Medicine, Director, North Florida AHEC Program, 408 West University Avenue, Suite 306, Gainesville, Florida 32601

The **University of Florida College of Medicine** initiated an Area Health Education Centers program in 1990. This program currently offers rural preceptorships for both third- and fourth-year medical students.

A comprehensive program for the recruitment of health professions students from medically underserved rural areas is underway and a number of retention activities designed to reduce the isolation of rural practitioners and increase their career satisfaction have been instituted. These activities include continuing medical education and consultation services for rural practitioners and improved access to library and informational services.

Source: Randolph Manning, Ed.D., Associate Dean for Student Affairs, College of Medicine, University of South Florida, 12901 Bruce B. Downs Blvd., MDC Box 4, Tampa, Florida 33612-4799

In 1984, the **University of South Florida College of Medicine** initiated the Public Sector Medicine program, designed to instill in medical students the desire to provide primary care to the medically indigent and underserved populations. Students learn skills of ambulatory care in a well organized clinic, which is taught by a multidisciplinary faculty and staff.

The program is conducted at the Judeo-Christian Health Clinic, a non-profit organization. Health professionals at the university and in the community volunteer their time to see patients and serve as faculty. In addition, clinics are held for migrant workers in two Florida communities. Students volunteer to participate during unscheduled class hours.

As many as 24 medical students are randomly chosen from 30-90 volunteers early in the second semester of their first year. Within four to six weeks, students begin direct patient care under the supervision of a preceptor; students are in groups of eight to ten per clinic session. They attend one afternoon clinic per week. Third- and fourth-year students undertake an independent study project on indigent and rural health needs.

GEORGIA

Source: David A. Wells, Director, Office of Rural Health, Medical College of Georgia, AE 1060, Augusta, Georgia 30912-3540

The **Medical College of Georgia's (MCG)** new Office of Rural Health is charged to expand and coordinate MCG's efforts in addressing the health care needs of Georgia's less-populous areas.

MCG's rural health office incorporates the faculty, staff, and resources of MCG's five schools—medicine, dentistry, nursing, allied health sciences, and graduate studies—as well as the MCG Hospital and Clinics. As a resource on rural health the office interacts with other state and federal agencies, and it fosters research and education in rural health.

This program helps solve the problems of physician distribution in Georgia. MCG's program joins efforts with existing bodies, such as the Governor's Commission on Access to Health Care. Pertinent issues, such as the lack of colleagues for physicians and lack of technology in rural Georgia, are the focus of this office and the Rural Health Council, a coalition of those at MCG interested in rural health care.

GEORGIA *continues on following page*

Source: Blumenthal, Daniel S. The Area Health Education Center: A Model of Community-Based Health Sciences Education. *Annals of Community-Oriented Education* 3, Part I(1990):85-90.

The **Morehouse School of Medicine** is one of four medical schools in the United States devoted primarily to producing black physicians. Its mission is to train primary care physicians to practice in medically underserved rural and inner-city communities, especially in minority communities. The Morehouse AHEC Program emphasizes training and serving minorities; the states it serves—Georgia and Alabama—are two of the poorest in the country.

The AHEC program includes three rural centers. One rural AHEC targets the southeastern quadrant of the state of Georgia, an area of approximately 19,000 square miles with a population of about 600,000. The second serves the southwest quadrant of the state, an area of similar size and population. The third rural AHEC serves a 20,000 square mile area that spans the state of Alabama in an east-west direction and covers about one fourth of the length of the state—a population of approximately 750,000. Health professionals in these areas are far from the academic medical centers and are at risk of professional isolation. Therefore, in addition to identifying rural sites for student clerkships, each AHEC offers approximately 120 conferences annually with a total of about 6,000 individuals in attendance. Morehouse medical students receive approximately 20 percent of their clinical education at AHEC sites.

HAWAII

Source: Christian L. Gulbrandsen, M.D., Dean, University of Hawaii John A. Burns School of Medicine, 1960 East-West Road, Honolulu, Hawaii 96822

The **University of Hawaii John A. Burns School of Medicine** Department of Family Practice and Community Health offers a required primary care clerkship for fourth-year students. The clerkship permits students to gain first-hand experience of primary care by working with physician preceptors in patient care, conferences, hospital admissions, emergencies, and other aspects of medical practice. The clerkships are four to eight weeks long on the six Hawaiian Islands; a minimum stay of six weeks is required for the preceptorships in Micronesia or in American Somoa.

ILLINOIS

Source: Phillip Davis, Ph.D., Director of Planning, Regional Medical Programs, Southern Illinois University School of Medicine, P.O. Box 19230, Springfield, Illinois 62794-9230

The mission of **Southern Illinois University (SIU) School of Medicine** is to produce physicians to practice in Illinois. Two-thirds of its students enter primary care specialties and about one-fourth enter family practice.

SIU's entire curriculum is organized to provide early, repeated clinical experiences. Active involvement by primary care physicians at each stage of student learning is complemented by active residencies in family practice, internal medicine, pediatrics, and medicine/pediatrics. Affiliation with community hospitals and heavy emphasis on ambulatory training provide students with a clear understanding of the rewards of primary care.

The Department of Family Practice participates in medical student clinical training in all four years of school. It provides clinical experiences for first-year students, organizes the sophomore year clinical medicine course, has a required junior year clerkship, and offers a full panel of electives. The undergraduate program is complemented by five affiliated residency programs distributed throughout downstate Illinois.

The centerpiece of the Department of Family Practice's undergraduate training effort is its required four-week preceptorship during the junior year. The preceptorship places 72 students each year in the offices of practicing family physician preceptors for an intensive experience in the actual practice of primary care.

The Department of Family Practice has affiliated residency programs in five downstate Illinois communities. As of January 1989, 34 percent of all SIU housestaff who had completed training—a total of 173 physicians—graduated from the Family Practice programs.

The School of Medicine maintains accredited residencies in medicine and pediatrics and also offers a four-year joint medicine/pediatrics program leading to board eligibility in both primary care specialties. A total of 70 residency positions are available.

Since SIU School of Medicine graduated its first class in 1975, 958 students have completed medical school training there. Of these, 557 have also finished residency training and are in practice. Forty-one percent (231) are practicing in Illinois. An additional 97 (17 percent) are in practice in contiguous states. Of these practicing graduates, 154 (27 percent) are family physicians. Half of all SIU family practice graduates have set up their practices in Illinois.

As of January, 1989, a total of 501 physicians completed residency or fellowship training in one of SIU's 18 residency or 11 fellowship programs. Of these, two-thirds completed a primary care residency, with over half of this group finishing family practice programs. Forty-eight percent (220) of all house staff alumni in practice are located in Illinois. Fifty-four percent located their initial practice in state. Of those housestaff who graduated from SIU School of Medicine, 66 percent (110) have stayed in Illinois to practice.

Source: B. Salafsky, Ph.D., Director, University of Illinois College of Medicine at Rockford and Rural Health Representative for the College of Medicine, 1601 Parkview Avenue, Rockford, Illinois 61107-1897

Approximately 50 percent of the graduates of the **University of Illinois College of Medicine** enter primary care residencies, although of the four sites (Chicago, Peoria, Rockford, and Urbana-Champaign) **Rockford**, at present, is the most involved in rural health issues. The current strategy involves a three-fold approach.

First, working in some 15 counties, high school science teachers have been supplied with materials relevant to careers in medicine. Summer fellowships are available to both science teachers and high school students. Secondly, faculty are located in programs in small rural hospitals in which family practice residents rotate. Thirdly, faculty associates work with rural practitioners, particularly those in solo practice, providing coverage and support.

INDIANA

Source: James E. Carter, M.D., Associate Dean, Student and Curricular Affairs, Indiana University School of Medicine, John D. VanNuys Medical Science Building 162, 635 Barnhill Dr., Indianapolis, Indiana, 46202-5120

Indiana University School of Medicine began a one-month clerkship in family medicine for third-year students in the fall of 1991. This clerkship covers concepts and skills in ambulatory medicine, primary care, preventive medicine, and rural medicine. Students are assigned to family practice preceptors throughout Indiana; some assignments are in rural areas.

IOWA

Source: Paul M. Seebohm, M.D., Consultant to the Dean, College of Medicine, The University of Iowa, Iowa City, Iowa 52242

The following reports have been submitted to the Iowa Board of Regents, the Legislature, and the Governor:

1. Office of Community-Based Programs. *University of Iowa College of Medicine Statewide Family Practice Training Program: Annual Report.* January 1991. 6 pp. (Brochure)

The Statewide Family Practice Training Program is in its 18th year. A total of 162 residents are currently enrolled in the programs. The 16-year average of retention of graduates in Iowa is 59 percent. During that period nearly half of those selecting Iowa sites chose communities with populations under 10,000.

The effect of the programs, plus the presence of a Department of Family Practice in the College of Medicine in Iowa City, on student interest in family practice as a career has been significant. Nearly one-quarter of the typical University of Iowa medical class enters family practice training after graduation. At more than twice the national average, the University of Iowa has been among the top five medical schools with the highest student interest in family practice over the past four years.

2. Office of Community-Based Programs. *University of Iowa College of Medicine: A Perspective—Family Physician Supply in Iowa.* January 1991. (4 pp.) Brochure.

The balance of family physicians entering and leaving practice was slightly positive in the late 70's and early 80's, but in 1985 and 1986 the number leaving practice in Iowa rose sharply and exceeded those entering practice until 1990.

By 1990 the outflow of young family physicians was no longer overrepresented among physicians who leave Iowa. Replacing many of the family physician losses has seen the emergence of a regional pattern of more than 200 medical branch offices statewide as a new source of medical services for towns with populations under 2,500 that at one time had one or two general practitioners. The medical branch offices are in the form of part-time satellite clinics, full-time associated practices, and hospital-sponsored clinics at remote rural sites.

The regional networks of primary care physicians are being organized and sponsored by major Iowa hospitals and multispecialty group practice organizations. The sponsors help attract family physicians to rural towns and provide practice management services and modern facilities. The improving professional environment, coupled with the Statewide Family Practice Training Program, is stabilizing the physician manpower situation in rural Iowa.

KANSAS

Source: Ronald K. Spangler, Director, Office of Institutional Research and Planning, The University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, Kansas 66103

University of Kansas Medical Center. *The 1990 Kansas Medically Underserved Areas Report in Conjunction with the Kansas Medical Scholarship Program.* Kansas City, Kansas: University of Kansas Medical Center, December 31, 1990. (pp. 1-88)

In 1978, the Kansas Legislature authorized two types of state-sponsored scholarships to be available to medical students attending the **University of Kansas Medical Center**. The scholarship law required recipients to enter a full-time practice in a medically underserved area in Kansas for the same number of years they received a scholarship. The Kansas Legislature later narrowed the focus of the scholarship to primary care for all students beginning the program after 1985. These recipients must complete a primary care residency and fulfill their service obligation in any Kansas city with a population under 12,000. The first recipients to practice under this provision will complete their residencies in 1993. Of a total of 64 counties determined to be medically underserved in primary care in 1990, 51 were determined to be critically underserved.

Across all specialties, in 1990, Kansas was served by approximately 3,510 full-time equivalents (FTE) nonfederal, practicing medical doctors and doctors of osteopathy. Of the total, 578 were enrolled in residency programs. The 1990 total of nonfederal practicing physicians represents a one-year gain of 147 FTE physicians in the state of Kansas. Primary care specialties increased by 28.

KENTUCKY

Source: Bryant, Oscar. Courting Country Doctors. *U. of Louisville Alumni Magazine.* 7 No. 4(Spring 1989):4-7.

Of Kentucky's 120 counties, 82 are underserved by physicians. Cooperative efforts by both the **University of Louisville (UL) and the University of Kentucky (UK) Health Sciences Centers** and the **Kentucky State University (KSU)** are underway to improve the population/doctor ratios in underserved counties.

In 1985 six Area Health Education Centers (AHECs) were established. Managed by UL and UK health sciences centers, they emphasize and promote primary care, provide training for UL and UK health professions students, and develop health careers awareness programs for disadvantaged and minority high school students.

The Professional Education Preparation Program (PEPP), which is operated by both UL and UK for the Kentucky Council on Higher Education, the Guaranteed Entrance to Medical School Program (GEMS), and the Medical Education Development Program (MED), are laying the foundation to provide sufficient numbers of health care practitioners to rural Kentucky:

1. In PEPP, UL, UK, and KSU identify high school students with interests in health careers, introduce them to special science-oriented seminars during the summer, and assist them in pursuing health education following high school.

2. A college undergraduate student who maintains a 3.3 GPA and scores at or above the national average on the MCAT exam is guaranteed admission to medical school through the GEMS program. In addition, GEMS candidates also receive attention from volunteer faculty and student mentors.

3. MED is UL's five-year program that assists capable but educationally disadvantaged students in obtaining a medical education. Students are immersed in a rigorous year of study, which consists of two first-year medical courses, an upper-level undergraduate science course, and seminars on time management, study skills, and stress management. Success in that first year ensures admission to the UL's School of Medicine and a one-year, full tuition scholarship that is considered annually for renewal.

Source: Michael E. Byrne, Deputy Director Kentucky AHEC, 55A, Room 106, School of Medicine, University of Louisville, Louisville, Kentucky 40292

University of Louisville School of Medicine. *Area Health Education Center Competing Continuation Grant Application to the Department of Health and Human Services*. Unpublished. November 1990. (325 pp.)

"Since 1985 the Kentucky Area Health Education Center (AHEC) System has been a cooperative effort of the **University of Louisville (UL) Health Sciences Center** and the **University of Kentucky (UK) Medical Center** that encourages health professions students to receive a portion of their education in clinical settings in rural or other underserved areas. In six rural AHECs, health professions students spend four to eight weeks learning under the direction of a rural health practitioner."

The UL statewide Physician Placement Service provides a program to assist all communities, particularly the underserved, in recruiting and retaining physicians. The Physician Placement Service initiates contact between physician candidates and the communities and provides systematic follow-ups in the matching efforts.

LOUISIANA

Source: Warren C. Plauché, M.D., Project Director, Louisiana Area Health Education Center, School of Medicine in New Orleans, Louisiana State University, 1542 Tulane Ave., New Orleans, Louisiana 70112-2822

Louisiana State University School of Medicine-New Orleans is in the third year of development of a statewide system of AHECs. Each AHEC supports rural physicians with continuing education programs and library and data searches through Learning Resource Centers.

Primary Care 120, an introductory course, encompasses four primary care clinical specialties—family medicine, medicine, obstetrics and gynecology, and pediatrics. In this four-week elective with rural preceptor physicians medical students have an opportunity to observe and experience community-based primary medical care. The course is offered between the freshman and sophomore year.

LOUISIANA *continues on following page*

Source: James R. Bardsley, Ph.D., Assistant Dean for Plans and Programs, Louisiana State University Medical Center, School of Medicine in Shreveport, 1501 Kings Highway, Post Office Box 33932, Shreveport, Louisiana 71130-3932

Louisiana State University School of Medicine-Shreveport's (LSU-S) second-year medical students are eligible to participate in an AHEC-sponsored four-week elective rural primary care preceptorship. Among fourth-year electives that may also be sponsored by the North Louisiana AHEC are the following:

1. Four- and two-week electives at LSUMC-S/EA Conway Division Hospital in Monroe include family practice, internal medicine, pediatrics, obstetrics/gynecology, general surgery, orthopedics, emergency room, anesthesiology, and radiology. Responsibilities include patient assessment and management in ambulatory care, inpatient, and community clinic settings.

2. Four- and two-week electives are provided at Moss Regional Hospital in Lake Charles, Louisiana. Students work with physicians in family medicine, internal medicine, and pediatrics and attend clinics for ophthalmology, urology, otolaryngology, rheumatology, surgery, and gynecology.

3. In a four-week elective at LSUMC-S/EA Conway Division Hospital an "Acting Internship" is offered under supervision of faculty and senior residents. This clinical experience covers all facets of care of the obstetrics-gynecology patient.

4. Four-week preceptorships are also available with family practice physicians in Vivian, Homer, and Haughton, Louisiana.

MARYLAND

Source: Harry C. Holloway, M.D., Deputy Dean, Uniformed Services University of the Health Sciences, F. Edward Hébert School of Medicine, 4301 Jones Bridge Road, Bethesda, Maryland 20814-4799

Portions of the **Uniformed Services University of the Health Sciences (USUHS)** third-year family practice clerkship address the physician's role in the community, health economics, and practice management. In the fourth year students study operational medicine in the required four-week Military Contingency Medicine (MCM) course. Students learn about operating in remote areas during disasters and emergencies. Fourth-year electives also allow USUHS students to complete family practice, internal medicine, and/or pediatric clerkships in remote areas of the United States.

Approximately six students, members of the United States Public Health Service (USPHS), are prepared through training with the USPHS to serve in rural areas. Their training begins in their orientation program, just prior to matriculating to USUHS. These students complete the five-week Military Medical Field Studies requirement of the first year in a remote area. Monthly meetings, organized by the USPHS, are also held to educate students with regard to service in rural or remote areas.

Source: Donald E. Wilson, M.D., Dean, University of Maryland School of Medicine, Campus for the Professions, 655 West Baltimore St., Baltimore, Maryland 21201

In its 15 years of operation, the Western Maryland AHEC has been remarkably successful in its role of influencing ultimate career selection. Of all the medical students from the **University of Maryland School of Medicine** who have participated in this program, 40 percent have chosen to practice in rural areas or small towns.

MASSACHUSETTS

Source: John F. McCahan, M.D., Associate Dean, Boston University School of Medicine, 80 East Concord Street, Boston, Massachusetts 02118-2394

Since 1972 **Boston University (BU) School of Medicine** has had a fourth-year elective that enables students to spend one month with a rural family practitioner. BU's School of Medicine also has the Primary Care Society, a student organization that seeks to supplement the traditional medical school curricula with information and experiences relevant to those considering a career in one of the primary care specialties. Activities include meetings with civilian and military family practice residents, family practitioners from rural and urban settings, residency directors and instructors, and visits from the presidents of both the Massachusetts and American Academy of Family Physicians. Presentations have also been made by a general internist, a pediatrician, and a gerontologist.

Source: Shepard N. Cohen, Associate Dean/Director, Graduate Medical Education, University of Massachusetts Medical Center, 55 Lake Avenue North, Room S2-332, Worcester, Massachusetts 01655

The ultimate purpose of the **University of Massachusetts Medical Center/** Statewide AHEC Program's Community Medical Practice Collaborative is to increase the number of primary care physicians practicing in Massachusetts and the number of other physician specialists practicing in underserved areas. This includes establishment of a focused, coordinated program for physician placement and retention, with emphasis on primary care specialties and underserved communities; collaboration among those educational and public service activities and resources within AHEC and the University of Massachusetts Medical Center that are supportive of these physician recruitment goals; initiation of innovative outreach and community service activities related to recruitment and retention; and development of additional resources earmarked for community-based recruitment and retention activities.

Source: Patricia A. McPartland, Ed.D., Executive Director, Southeastern Massachusetts AHEC, 2 Spring Street, P.O. Box 280, Marion, Massachusetts 02738

The **University of Massachusetts Medical School (UMMS)**, Department of Family and Community Medicine in collaboration with Southeastern Massachusetts Area Health Education Center (SMAHEC), has developed third- and fourth-year preceptorships with office-based primary care physicians, especially specialists in family medicine. All fourth-year students take a required six-week rotation in Family and Community Medicine, which provides

additional exposure to primary and preventive medicine. Approximately nine to twelve UMMS medical students participate in a six-week clerkship with family practitioners in Southeastern Massachusetts each year. The goal of the family medicine clerkship is (1) to provide training for UMMS medical students in office-based, primary care medicine in diverse communities, (2) to increase the proportion of UMMC students who elect family medicine as a specialty, and (3) to provide opportunities for practicing physicians to teach.

MINNESOTA

Source: Elizabeth Canan, Systems and Procedures/Regional Planning, S-33 Eisenberg Building, Mayo Clinic, 201 West Center St., Rochester, Minnesota 55905

Mayo Medical School medical students are exposed for four weeks to family physicians as teachers and role models. This begins early in the second year with one week of didactics (concepts of family medicine) and followed by a one-week preceptorship with a rural family practitioner that emphasizes the therapeutic nature of the doctor/patient relationship and the importance of availability and continuity of medical care. In the latter part of the second year, each medical student is again hosted for two weeks by one of the Mayo Medical School's family practitioner preceptors—in the preceptor's medical practice, hospital, and home. This experience provides students with an atmosphere in which they test some clinical skills and gain new skills.

Faculty feel that the preceptorship with family physicians in rural areas affords students with a valuable experience away from Rochester and allows them to work side-by-side with a family physician in order to understand this type of practice outside the medical school environment.

The Mayo Foundation operates a Family Practice Clinic in Kasson, Minnesota, a town of 3,000 people. In 1990, there were 31,000 patient visits for obstetrics care, pediatrics, geriatric medicine, and acute minor trauma. Practitioners in this setting also care for a large nursing home population, make house calls, and serve as volunteers in the local ambulance service.

Nineteen residents are in the family medicine program, all of whom have their outpatient experience at the Kasson Clinic. About 40 percent of the residents graduating from this program enter into a rural-based practice.

Source: James G. Boulger, Ph.D., Associate Professor, Behavioral Sciences and Director, Family Practice Preceptorship, Department of Behavioral Sciences, University of Minnesota-Duluth School of Medicine, 10 University Drive, Duluth, Minnesota 55812-2487

Boulger, J. G. Family Medicine Education and Rural Health: A Response to Present and Future Needs. *J. Rural Health* 7(Spring 1991):105-115.

The educational program at the **University of Minnesota, Duluth, School of Medicine** has achieved a great deal of success in training rural family physicians. A coordinated program effort, featuring the efforts of more than 200 family physicians during the past 15 years, has led to 52.5 percent of all graduates selecting family practice and more than 41 percent choosing practice sites with a population fewer than 20,000.

"The University of Minnesota, Duluth, School of Medicine is currently the only separately accredited institution offering the first two years of medical school in the United States. Following successful completion of their first two

years in Duluth, students are accepted on a noncompetitive basis for completion of their medical school studies at the medical school of the University of Minnesota in Minneapolis. Since the first class of students began their studies in Duluth in 1972, the goal of the program has been to train students who will be likely to select the specialty of family practice in rural and other nonurban areas of the state and region.

"The National Rural Health Association selected the University of Minnesota, Duluth, School of Medicine as the recipient of its 1990 award for the most outstanding rural health program in the United States. More specifically, the Family Practice Preceptorship Program was named the primary factor in the overall success of the school in training medical students who subsequently enter family medicine and rural health practice at a higher rate than any other program in the country.

The Family Practice Preceptorship Program is required of all students in both years of the curriculum. The purpose of the preceptorship program is not to teach clinical medicine, but to illustrate the benefits, as well as the disadvantages, of small community practice.

"During the first year of medical school, each student is assigned to a family physician who practices within a 30-mile radius of the school of medicine. Students meet with their preceptors 10 times during the course of the academic year. Each preceptor has only one student; no other activities are scheduled during these times within the medical school curriculum. The student is exposed to the entire range of activities of the preceptor. The preceptorship sessions begin during the eighth week of medical school and continue through the first year at approximately three-week intervals.

"During the second year, each student is matched with and assigned to a family physician preceptor in a smaller community; the student is scheduled to be with the preceptor for three consecutive days (and nights) midway through each academic quarter. During the three-day visits, virtually all of the students live with the preceptor and his or her family to maximize the students' exposure to the everyday working environment of the small community family physician and the lifestyle of that physician in the nonurban setting.

"Physicians in both the first- and second-year family practice preceptorships are offered clinical appointments on the faculty of the school of medicine at Duluth. Local family practitioners and family practice residents also serve as clinical instructors in the second year of medical school as the students take mini-clerkships, which require one patient work-up each week.

"Beginning in the 1990 academic year, a selective mini-course was offered to first-year students in behavioral sciences on rural health. This includes discussion of rural health care opportunities and problems, consequences of maldistribution on the health of rural Americans, the need for physicians in the care of the American Indian rural population, and the development of public policies on rural health on both the state and national levels. In addition to these sessions within the formal curricular structure, local family physicians and the local AAFP chapter are also involved in the school's Family Practice Interest Group which actively engages students in evening sessions of an informal nature during the year."

Source: John W. LaBree, M.D., Professor of Medicine, Director of Medical Outreach, University of Minnesota Medical Outreach Office, C-134 Mayo Memorial Building, 420 Delaware Street, S.E., Minneapolis, Minnesota 55455

The Minnesota Center for Rural Health, with its main office in Duluth, is a multidisciplinary effort representing most of the provider groups in the state: the Minnesota Medical Association, the Academy of Family Practice, the

Minnesota Hospital Association, the Senior Citizen Federation, the Long-Term Care Association, and the public at large. It is also affiliated with the University of Minnesota, Duluth, School of Medicine. The University of Minnesota, Twin Cities, is a partner in this effort through the **University of Minnesota Hospital and Clinic**. Currently the Center's major priority is in physician recruitment.

MISSOURI

Source: W. C. Allen, M.D., Professor Emeritus, University of Missouri-Columbia School of Medicine, Department of Family and Community Medicine, M228 Medical Sciences Building, Columbia, Missouri 65212

Dr. W. C. Allen completed a study of **Missouri-Columbia** graduates as of November 1990. Of Missouri-Columbia graduates who chose to enter family practice, if their post-graduate training was in a family practice residency in Missouri, 73 percent entered practice in Missouri. Of those, 89 percent are board certified in family practice. The size of community in which the graduates locate is as follows:

Less than 1,000 population, 4 percent; 1,001 to 2,500 population, 17 percent; 2,501 to 25,000 population, 40 percent; 25,001 to 100,000 population, 17 percent; 100,001 to 250,000 population, 5 percent; and 250,001 to 500,000 population, 18 percent. Three of those in St. Louis and Kansas City are in inner city practices. From 1970 through 1984, the average number going into family practice from each class is a little over 19 percent.

The University of Missouri School of Medicine compiles annually a directory of practice opportunities available throughout the state. This resource is forwarded with a letter from the dean to Missouri-Columbia graduates who are completing their residencies.

Source: Mabel L. Purkerson, M.D., Associate Dean for Curriculum, Washington University School of Medicine, Box 8077, 660 South Euclid Ave., St. Louis, Missouri 63110

Washington University School of Medicine offers fourth-year electives in internal medicine and general surgery at the Keokuk Area Hospital in Keokuk, Iowa. Students experience the excitement of general internal medicine preceptorships in a small community without medical subspecialists. The students work with a group of three internists.

Student exposure includes consultations from general surgeons and family practitioners plus other responsibilities of the general internal medicine group, which include treadmill exercise testing, echocardiograms, Holter Monitor analysis and interpretation, routine daily electrocardiogram interpretation, and pulmonary function testing. While the emphasis of the experience is on ambulatory care, the students have direct inpatient care responsibility including the evaluation and treatment of admissions to the Critical Care Unit. The students have access to all aspects of the medical group's practice, including skin testing as part of allergy and clinical immunology, esophagogastroduodenoscopy, colonoscopy, and bronchoscopy.

MONTANA

Source: Frank S. Newman, Ph.D., Director, Montana Area Health Education Center, Culbertson Hall, Room 308, Montana State University, Bozeman, Montana 59717

The **Montana Area Health Education Center (AHEC)** has three initiatives to increase the number of physicians practicing in Montana:

Montana is one of two states without a freestanding family practice residency program. The Montana Family Practice Residency Satellite Program was developed in 1982 through the cooperative efforts of the WAMI (Washington, Alaska, Montana, Idaho) Medical Program, Montana Medical Association, Montana Academy of Family Physicians, Montana Hospital Association, and physicians and hospitals from throughout Montana. This program provides opportunities for residents training in accredited family practice residency programs in other states to come to Montana for a one- or two-month rotation under the supervision of a Montana physician. More than 100 physicians participate in this program in over 30 "satellite units" (residency sites) in Montana. One of the goals of the Montana Family Practice Residency Satellite Program is to increase the number of physicians making knowledgeable choices to practice in Montana.

The Rural/Underserved Opportunities Program (R/UOP), a program of the Montana Area Health Education Center (Montana AHEC), in affiliation with the Regional AHEC Program at the University of Washington School of Medicine, provides opportunities for medical students to learn about the practice of medicine in rural and underserved areas of Montana.

First-year medical students at the University of Washington School of Medicine in Seattle and at each of the WAMI sites in Washington (Pullman), Alaska (Anchorage), Montana (Bozeman), and Idaho (Moscow) can apply for the R/UOP as an elective rotation following the completion of the first year of medicine. The students spend from four to six weeks in the clinic of a practicing rural physician in one of the four states. Physicians throughout the four-state region volunteer their time and resources to provide this educational experience.

During the Summer of 1991, 12 medical students completed rural rotations in Montana through the R/UOP. Over 90 primary care physicians in Montana have volunteered to serve as preceptors for this program.

The Montana Health Manpower Information Center and Recruitment Program is an activity of the Montana Office of Rural Health, Montana Area Health Education Centers (Montana AHEC), and Montana Primary Care Cooperative Agreement. This program serves as a clearinghouse for physician and other health care provider needs in Montana and supports rural recruitment efforts.

NEBRASKA

Source: O'Brien, R. L. Rural Health—Educators Respond. *Cornhusker Family Physician* (Winter 1991):8-9.

Creighton University Medical Center's Commitments to Rural Health Care in Nebraska and nearby Midwestern states are outlined in this article. Among its clinical support services for patients and physicians in rural areas are remote 24-hour cardiac monitoring, 24-hour phone line electrocardiogram interpretation, a cardiac emergency network providing early treatment of coronary artery thrombosis and other emergencies, a reference laboratory providing full pathology and toxicology services for physicians and others, and Saint Joseph Hospital Life-Flight helicopter emergency transportation.

To improve access of rural residents to specialty physicians, Creighton operates several outreach programs providing on-site consultations in smaller communities. This diminishes travel by patients and allows them to stay under the direct day-to-day care of primary physicians.

Many efforts are specifically addressed to needs of rural areas. Creighton provides rural preceptorships to its medical students. Rotations in family medicine are also available to all residents.

Creighton sponsors continuing education programs for rural physicians. Its Geriatric Education Center, serving rural Nebraska and Wyoming, has presented 65 to 70 continuing education programs to professional groups during the last two years.

Source: Leslee B. Shell, Rural Health Coordinator, University of Nebraska Medical Center, Office of the Dean, 600 South 42nd St., Omaha, Nebraska 68198-6545

1. Shell, Leslee B., et al. *The Rural Health Education Network (RHEN) at the University of Nebraska Medical Center: An Innovative Statewide Approach to the Education of Rural Health Professionals.* Unpublished. November 1991.

Through the Rural Health Education Network (RHEN), 93 non-metropolitan Nebraska communities are collaborating in a partnership with the **University of Nebraska Medical Center (UNMC)** to develop educational resources in rural settings. These communities will be used for early and repeated exposure of students to primary care role models with the goal of improving the availability of health professionals in the underserved and rural areas of the state.

2. Moore, Gerald F., et al. *Change in Application/Acceptance Rates as a Result of the Rural Health Opportunities Program at the University of Nebraska.* Unpublished. 1991.

The Rural Health Opportunities Program (RHOP) was instituted in 1990 to guarantee early admission to academic programs at the **University of Nebraska Medical Center**. High school graduates or other individuals with unique backgrounds are given conditional acceptances into medical school, physician assistant, medical technology, dental, and dental hygiene programs. The program encourages rural residents to go into health careers through wavier of tuition for undergraduate education, guaranteed early admission, and reduced length of time in undergraduate training. The program began in Fall, 1990 with 11 medical students admitted to **Chadron State College**; 12 have been admitted in 1991. RHOP has been expanded this year to include **Wayne State College**, with five medical students starting at Wayne in the Fall of 1991. Joint admissions committees from UNMC, Chadron State College, and Wayne State College select applicants and monitor their progress.

3. Waldman, Robert H. (Principal Investigator). *Preparing Physicians for the Future: A Program in Medical Education.* (Unpublished Project Summary). Grant No. 17243 from the Robert Wood Johnson Foundation, 1990. 22 pp.

The University of Nebraska Medical Center plans to improve the education of primary care physicians for the state of Nebraska through the creation of centers for medical education in underserved rural communities. Additional components will be the continued reassessment and integration of basic science and clinical instruction throughout the four years of medical school emphasizing student-centered, problem-based, small-group educational methods. A number of additional initiatives to address physician supply in rural areas at the University of Nebraska Medical Center are described.

(1) In rural Nebraska communities where there are no pediatricians, most children with special medical needs receive primary medical care from general practitioners and family physicians and are referred outside of their communities for specialty, pediatric services. They often have to travel significant distances or are referred to Omaha or Denver to obtain secondary and tertiary pediatric care for their special health care needs. The Rural Partnership for Children project links pediatricians with local family physicians in four communities in the Nebraska Panhandle. In this program, a team of pediatricians spend one to two days a month in physician's offices in designated four-county areas. Consulting pediatricians work alongside the local medical providers in monthly Pediatric Consultation Service Clinics.

(2) Established as a two-hour course in the University of Nebraska College of Medicine, the Primary Care Ambulatory Medicine course provides freshmen students with early introduction to family medicine. This year, 80 students are spending a "rural weekend" with physicians in rural Nebraska; 40 students are visiting community- or University-based preceptors monthly. In 1991-92, the entire class (120 students) will see preceptors monthly, and all students will also go on a rural weekend.

(3) The Rural Health Education Network (RHEN) Summer Primary Care Fellowship is a one-month experience in a community primary care setting. The rotation occurs in a summer month at the end of the freshman year. Students spend time in rural preceptors' offices in RHEN spoke communities. Didactic sessions throughout the experience highlight unique aspects of primary care, discuss core clinical problems in primary care medicine, and reemphasize critical interviewing and physical diagnosis skills. The program began in 1991 with a pilot group of 20 students.

4. Waldman, Robert H., Wigton, Robert W., and Leslee B. Shell. Physicians for Rural Nebraska—A Comment on the Report of the Commission on Medical Education. *Nebraska Medical Journal* 74(1989):288, 292.

The College of Medicine at the University of Nebraska Medical Center has been concerned with the need for more physicians in rural areas of the state. The authors describe a number of programs aimed at increasing the likelihood that graduates will practice in rural Nebraska.

NEW HAMPSHIRE

Source: Joseph F. O'Donnell, M.D., Associate Dean for Student Affairs, Dartmouth Medical School, Hanover, New Hampshire 03756

In 1991, the **Brown-Dartmouth** Cross Cultural and International Health Initiative began to build an institutional relationship with the Yukon-Kuskokwim Health Corporation and the Bethel Service Unit of the Indian Health Service, in Bethel, Alaska. The main purpose for establishing this relationship was to provide opportunities for faculty and student exchange for education, service, and research around issues of primary medical care for underserved, rural populations. Several activities have been initiated that are expected to develop into a continuous, close relationship with those providing services to the primarily Yupik, Eskimo population.

The Department of Community and Family Medicine has recently initiated development of Bethel-area health services as one site for the required primary care clerkship offered in the third year of medical school. The main purpose of offering the Bethel opportunity to students in primary care is to provide them with positive experiences of potential careers in rural, underserved, minority populations particularly with the Indian Health Service.

Mount Mooselaukee Health Center, a community health center, provides primary care to one of the poorest and most isolated areas in the White Mountains. The Health Center is currently staffed by a physician from the faculty of the **Dartmouth Medical School** three days per week. Services include a well child program, a women's health clinic, a prenatal service, family health care, and volunteer health outreach to the homebound.

Several New Hampshire and Vermont towns, and one in Massachusetts, are served by Hanover-based physicians representing many different specialties.

The **Hitchcock Clinic**, through its outreach activities, has been providing medical services to outlying communities since 1976. In addition to these outreach specialty clinics, community-based clinics have been established in three towns in New Hampshire and three towns in Vermont. These are staffed by Hitchcock-employed providers who live and practice in these areas. The Hitchcock Clinic also has an office in Canaan, New Hampshire, which is staffed by Hanover-based providers offering pediatric and obstetrics and gynecology services. Through these various activities, the Hitchcock Clinic is able to offer specialty and primary care to patients in their own communities. These arrangements provide for improved communications and coordination of medical care between Hanover-based physicians and local providers.

NEW MEXICO

Source: Jo Fairbanks, Ph.D., AHEC Program Coordinator, University of New Mexico School of Medicine, 2701 Frontier NE, Albuquerque, New Mexico 87131-3061

A number of rural health programs at the **University of New Mexico School of Medicine** have been described [*Acad. Med.* 65(December Supplement 1990):S69-S70.]. Recent initiatives in the Department of Family, Community, and Emergency Medicine are reported:

1. The Rural Resident Grant permits expansion of the number of family medicine residency positions and the development of a community-oriented curriculum for family practice residents appropriate for health care needs of rural and urban underserved populations in New Mexico. The program will develop four rural and three urban underserved sites that will broaden all residents' training experiences. The project develops a curriculum that will equip residents, on-campus faculty, and off-campus preceptors with skills in community-oriented primary care.

2. The Health Education Training Center Grant has as its purpose developing existing human resources in rural and border health; training health professional students in rural and border health; training new and established health professionals and the public in health promotion and health education appropriate to border and rural communities; and creating opportunities for minority students to learn about and, ultimately, to enter health professions. The goal of this program is to develop and organize resources and training materials for health professionals and health professional students that will improve the supply, distribution, quality, and efficiency of personnel providing health services along the New Mexico/Mexico border.

NEW YORK

Source: Bonnell D. Kaido, Assistant Director of Medical Education, The Mary Imogene Bassett Hospital, One Atwell Road, Cooperstown, New York 13326-1394

The **Mary Imogene Bassett Hospital** is a major teaching affiliate of **Columbia University College of Physicians and Surgeons, University of Rochester School of Medicine and Dentistry, Dartmouth Medical School, Albany Medical College**, and a limited affiliate of **SUNY Health Sciences Center at Syracuse**. The hospital is organized as a group practice with 140 full-time, salaried, attending physicians with offices either in the hospital or in one of 15 Regional Community Health Centers within a 50-mile radius of Cooperstown.

The Hospital and Health Centers are members of the Bassett Health System, which also includes The Bassett Medical Research Institute, including the New York State Center for Agricultural Medicine and Health, and the Community Health Plan of Bassett, a health maintenance organization, and O'Connor Division, a 28-bed acute care hospital in rural Delhi, New York.

Bassett Hospital is located in rural, upstate New York in a community of 2,400 people. The Hospital is both a primary and tertiary care provider, with a primary catchment area of 250,000 and a regional area of 750,000. Bassett Hospital has a number of programs designed to attract students interested in

learning primary care internal medicine who may choose to practice in a rural area:

1. Rochester-Bassett Medicine Practice-Based Clerkship—Third-year students from the **University of Rochester School of Medicine and Dentistry** rotate to one of the clinics in the Bassett Health System for a six-week experience working with a general internist. The students meet each Wednesday at the Cooperstown campus for Interdepartmental Grand Rounds and an integrated teaching session with students from the **Dartmouth** Primary Care and Neurology programs and **Albany's** Medicine III clerkship.

2. Dartmouth-Bassett Primary Care Clerkship—Third-year students from **Dartmouth Medical School** spend four weeks in either Bassett's Prime Care (general internal medicine) outpatient clinic or in one of the Regional Community Health Center practices. The program is designed to give an intensive experience working with a generalist emphasizing particularly initial and follow-up care of new and established patients.

3. Albany-Bassett Medicine III Clerkship—Bassett provides one of three monthly rotations to **Albany Medical College** third-year students in the required Medicine III clerkship. This rotation, while focusing mainly on the inpatient side, introduces students to the type of patient mix found in the rural tertiary care center.

4. Bassett Rural Primary Care Internal Medicine Residency Program—Bassett Hospital received funding in 1990 to establish a rural primary care track to complement existing internal medicine training programs in the categorical and preliminary tracks. Funding was provided through a Health and Human Services grant submitted by James T. Dalton, M.D., a general internist in Bassett's Prime Care Clinic. (See following description.)

Source: James T. Dalton, M.D., Assistant Program Director Department of Medicine, The Mary Imogene Bassett Hospital, One Atwell Road, Cooperstown, New York 13326-1394

The Mary Imogene Bassett Hospital (MIBH) Rural Primary Care Internal Medicine program was established to produce well trained primary care internists. Achieving that goal involves development, modification, and utilization of MIBH resources.

Curricular differences between the Rural Primary Care Internal Medicine program and the Categorical Medicine program include the following:

1. A core curriculum emphasizes ambulatory and general internal medicine topics, which supplement the subspecialty curricula and include topics in preventive medicine, clinical epidemiology, behavioral medicine, and occupational medicine as it relates to rural populations.

2. A block rotation in behavioral medicine, includes exposure to behavior modification, risk factor management in preventive medicine, office-based counseling, outpatient medical/psychiatric liaison, and alcohol/substance abuse counseling.

3. One extended block rotation in each of the PGY-2 and PGY-3 years are spent at outreach sites, which exposes the residents to multiple rural practice models.

4. More extensive research opportunities in rural medicine and primary care are offered.

5. Block rotations in outpatient medicine in the PGY-2 and PGY-3 years, comprised of expanded continuity clinics, related specialty clinics, Farm Health/Occupational Medicine clinics, and a geriatric experience.

6. Opportunities in rural community medicine are provided.

Source: Karl P. Adler, M.D., Dean and Vice President for Medical Affairs, New York Medical College, Valhalla, New York 10595

The Department of Family Medicine of **New York Medical College** sponsors the Mid-Hudson Clinical Campus for Primary Care located in Ulster and Dutchess Counties, New York. Two major objectives of this Clinical Campus are to encourage medical students to enter primary care as a career choice and recruit graduating family practice residents to settle in small communities in rural areas. This program has attracted over 40 graduates of the resident training programs to rural or semi-rural locations of practice. Over 75 percent of these graduates are practicing in communities of less than 10,000 people, principally in the Mid-Hudson region.

The recent development of the Primary Care Medical Student Training Programs at New York Medical College provides office preceptorships and ambulatory experience on a graduated basis for medical students throughout the entire four years of medical school. Many of these students elect this training experience within the Mid-Hudson Clinical Campus for Primary Care.

Source: Thomas C. Rosenthal, M.D., Director, Office of Rural Health, Department of Family Medicine, School of Medicine and Biomedical Sciences, State University of New York, 462 Grider Street, Buffalo, New York 14215

In association with the Department of Family Medicine at the **State University of New York (SUNY) at Buffalo School of Medicine and Biomedical Sciences**, the Cuba Memorial Hospital's Rural Health Campus has the following objectives: (1) development of a new diagnostic and treatment center as an extension clinic of Cuba Memorial Hospital to provide a full range of family practice services including obstetrics and outreach and prevention programs; (2) development of a rural family medicine residency training program affiliated with SUNY at Buffalo School of Medicine and Biomedical Science that will train residents, medical students, and nurse practitioners; (3) development of an education center for training rural area providers in the provision of health care to developmentally disabled citizens in cooperation with the New York State Office of Mental Retardation and Developmental Disabilities; (4) establishment of community-oriented primary care by involving trainees in outreach projects.

The rural campus is located on the grounds of Cuba Memorial Hospital (a non-profit, voluntary, 26-bed acute care and 61-bed skilled nursing facility) in the village of Cuba in northwestern Allegany County with a satellite in Belfast 16 miles to the east. Since 1987, Cuba has been targeted by the New York State Health Department as a priority medically underserved area.

The project emulates the proposed federal model of rural primary care centers (Cuba Memorial Hospital) affiliated with an essential access health center (Olean General Hospital, a 153-bed rural referral center 15 miles away). Operated by Cuba Memorial Hospital, the Campus will have four family physicians and one nurse practitioner. They will reside in the community and hold faculty appointments at SUNY Buffalo. By 1993 this site will be caring for 18,000 annual patient visits, 160 pregnancies, and 100 developmentally disabled clients.

NEW YORK *continues on following page*

Source: Robert Schwartz, M.D., Acting Chairman, Department of Family Medicine, State University of New York at Stony Brook, Stony Brook, New York 11794-8461

An initiative of **State University of New York at Stony Brook Health Sciences Center School of Medicine's** Department of Family Medicine involves rotations at the Navajo Nation Health Foundation Sage Memorial Hospital, Ganado, Arizona. The Department of Family Medicine has developed a long-term relationship with Sage Memorial Hospital to train both family medicine residents and medical students in special medical problems faced by Native Americans living on reservations. Residency rotations and student fourth-year electives are of one-month duration.

The SUNY-Stony Brook Summer Preceptorship Program was developed and is administered by the Department of Family Medicine as an introduction to family practice for first- and second-year medical students. The program utilizes private practices in rural areas of New York, Maine, New Hampshire, Connecticut, and Rhode Island.

Source: Philip G. Holtzapple, M.D., Associate Dean for Medical Curriculum, State University of New York, Syracuse Health Science Center, 8310 Weiskotten Hall, 750 E. Adams St., Syracuse, New York 13210

The **State University of New York Health Science Center at Syracuse College of Medicine's** Rural Medical Education Program (RMED), begun in 1990, is an outgrowth of the Extended Rural Preceptorship, which was described earlier [*Acad. Med.* 69(December Supplement 1990):S71]. Through RMED the Department of Family Medicine places a small number of third-year medical students in rural communities full-time for nine consecutive months to work and learn under the supervision of board certified family physicians and other specialists. Full academic credit is earned for this experience. Students live in the rural community, returning to their home campus at the end of the course to complete their studies for the M. D. degree.

The educational goals of the program are to broaden the student's knowledge base; provide greatly expanded opportunities for the student to sharpen clinical skills; develop the student's skills in clinical problem-solving and patient management; introduce the student to the practice of continuous and comprehensive medical care; help the student develop independent learning skills; and foster positive attitudes toward patient care in the primary care and ambulatory setting.

Additionally, program goals for this project are to add flexibility to the undergraduate clinical curriculum to better meet the needs of students considering careers in a primary care field in a non-urban setting; strengthen ties with rural physicians and hospitals in the Central New York area; provide rural physicians with high quality continuing medical education programs on a regular and frequent basis; help rural communities to retain and recruit physicians; and develop a rural network for more effective patient care and research activities.

The RMED program encompasses more than family medicine by providing the potential to partially or fully satisfy, under appropriate supervision, College of Medicine requirements in otolaryngology, geriatrics, emergency medicine, orthopedics, radiology, ophthalmology, urology, anesthesiology, obstetrics/gynecology, pediatrics, psychiatry, and preventive medicine.

NORTH CAROLINA

Source: Brown, J. T., Schradie, J. A., and Bader, S. C. The North Carolina Student Rural Health Coalition Enters the Medical School Curriculum: The Duke Rural Health Elective. *North Carolina Medical J.* 51(Aug 1990):385-388.

Duke University School of Medicine's Rural Health Elective is an innovative approach to address the health problems in North Carolina's rural areas and to influence medical education. When it was first offered in the fall 1989, seven students enrolled for the elective. Students taking the Rural Health Elective staff monthly rural clinics. In this role they schedule the medical students and preceptors, orient and train other student volunteers, record laboratory work done each month, and communicate the results to the patients, follow-up any needed patient referrals, and inventory and restock the needed medical supplies.

The second feature of the course is a seminar series. Topics have been chosen to allow the students to learn more about the history and social demographics of rural North Carolina, to understand the important barriers to health care that indigent people face, and to be introduced to the concept of community organization. The seminars enable the students to have a consistent forum to discuss how they can become better practitioners in a rural and community context. In the final activity of the course, each student plans and implements a rural health project.

Source: Thomas G. Irons, M.D., Professor of Pediatrics and Associate Dean, East Carolina University School of Medicine, Brody Medical Sciences Building, Greenville, North Carolina 27858-4354

East Carolina University (ECU) School of Medicine serves a largely rural area of North Carolina. Positive consideration is given to medical school applicants who are from rural areas of the state, especially from eastern North Carolina.

Several components of the medical school curriculum are presented with emphasis on rural health issues. The Department of Family Medicine emphasizes rural health care and practice to all the students with offerings in all four years of the medical curriculum.

As a part of the M-1 Primary Care Conference (a class given throughout the first half of the first year), there is a two-hour class on agricultural medicine, including occupational injuries and health risks of farmers. An additional two-hour class is developed in a farm site visit utilizing a small group format with a faculty member and an extension agent at each site. An additional one-hour class is given by the students who report various observations about their particular farm visit. Additionally, as part of the first- and second-year curriculum, all students are required to participate in two three-day preceptorships with family physicians usually located in rural North Carolina.

All students are required to serve eight-weeks in ECU's family medicine clinical clerkship. Approximately two-thirds of the students are assigned to offices of private physicians, most of which are in rural locations. One third of the students are assigned to the Family Practice Center at the medical school. All students spend six weeks in the clinical setting and two weeks in didactic presentations at the medical school. During the didactic sessions, a one-hour class is taught concerning farm health issues. A farm site visit in the practice locality is required of each student.

In order to facilitate medical information transfer to rural practice sites, students are instructed in the use of computers. Approximately half of the

students are provided with lap-top computers and printers for use at the practice sites. They are instructed in methods of accessing medical information systems, such as MEDLINE, for use with their preceptors in caring for patients actually seen by the students.

Optional experiences in rural family medicine are also offered for fourth-year students (non-required): Rural Medicine (two weeks), which involves attendance at a series of Saturday clinics held in a remote, rural community in eastern North Carolina; Migrant Health Clinic (one month) in which students work daily under supervision of a family physician faculty member; and Advanced Clinical Clerkship (one month), in a private family physician's rural practice.

Source: Robert G. Brame, M.D., Director, EAHEC, East Carolina University School of Medicine, Greenville, North Carolina 27835

Several recruitment and retention programs were reported:

East Carolina University (ECU) School of Medicine and Pitt County Memorial Hospital conducted the first annual spring recruiting medical fair in 1991. Representatives from regional hospitals were invited to the School of Medicine where they displayed exhibits describing their institutions and met with third- and fourth-year medical students and resident physicians.

Eastern Area Health Education Center (EAHEC) has been awarded a grant through Central AHEC in Chapel Hill for funds to employ a medical recruiter to be based in the AHEC office. That person will assist in recruiting students into programs offering education in the health care profession.

EAHEC and the ECU School of Medicine Continuing Medical Education office provide library support, consultation services through a university medical center hotline, and durable educational material support for physicians in the region. This is done as a matter of providing continuing medical education and also as a method whereby physicians can be attracted to the rural area and be made to feel that they have a contact with the University Medical Center rather than practicing in isolation.

Source: Eugene S. Mayer, M.D., M.P.H., Associate Dean, AHEC Program Director, CB# 7165, Medical School Wing C, University of North Carolina, Chapel Hill, North Carolina 27599-7165

1. Mayer, E. S., Academic Support for Rural Practice: The Role of Area Health Education Centers in the School of Medicine. *Acad. Med.* 65(1990):S45-S50. This article describes the North Carolina AHEC Program and its accomplishments since its inception in 1972. The author outlines achievements in the area of medical student education, primary care resident training, other health professions training, continuing education, technical assistance and consultative service, library and information services, and physician distribution.

2. North Carolina Area Health Education Centers Program. *Medical Education and Medical Manpower in North Carolina*. Chapel Hill, North Carolina: University of North Carolina School of Medicine, March 1990. 65 pp. This book is fifth in a series designed to show trends in physician distribution in North Carolina. The data show an improvement in the ratio of physicians to population relative to both the national average and relative to conditions in the early 1970s. The data show, however, that considerable work remains to be done to ensure an adequate distribution of physicians in North Carolina, one of the nation's most rural states.

3. North Carolina Area Health Education Centers Program. *North Carolina Health Careers '90—'91*. Chapel Hill, North Carolina: University of North

Carolina at Chapel Hill, October, 1990. 130 pp.

North Carolina students, counselors, and educators need information about the range of medical and other health careers, and about the requirements for admission, certification, and licensure. This publication covers 78 medical and associated fields, with information on each profession, recommended preparation, educational requirements, requirements for practice, salaries, and all educational programs available in North Carolina. Information on financial aid is also provided.

The North Carolina AHEC Program produced this publication for middle- and high-school teachers, counselors, and students, as well as for libraries, employment centers, hospital personnel officers, and educational institutions. Its purpose was to increase interest in health careers and to encourage better academic preparation for those careers by reaching students earlier in their school careers.

NORTH DAKOTA

Source: Clayton Jensen, M.D., and Martee Buschfield, Ph.D., Department of Family Medicine, University of North Dakota School of Medicine, 501 N. Columbia Road, Grand Forks, North Dakota 58203

The **University of North Dakota School of Medicine** has a five-phase curriculum in undergraduate medical education. Phase III and Phase V occur in rural community hospitals. By observing hospital staff, developing procedural skills, and integrating into the communities students are encouraged to establish practices in rural areas.

Phase III provides the transition from preclinical training to clinical training, on the wards of hospitals. Phase V provides a transition between undergraduate and graduate medical training with a rural emphasis. Phase V students have completed the majority of the curriculum of the University of North Dakota School of Medicine and usually return to the same site in which they received their Phase III training. Phase III and Phase V sites are located in 25 rural hospitals throughout the state of North Dakota.

OHIO

Source: Ned E. Baker, M.P.H., AHEC Program Director, Medical College of Ohio, P.O. Box 10008, Toledo, Ohio 43699-0008

Two academic departments at the **Medical College of Ohio (MCO)**—the Department of Family Medicine and the Department of Pediatrics—provide third- and fourth-year medical students the opportunity to develop and implement educational programs in health promotion and disease prevention through community health education clerkships at one of the Medical College of Ohio's three Area Health Education Center (AHEC) programs in Sandusky, Lima, or Bryan. Students may choose from one of three programs: minority elderly program; migrant farm workers program; and school-age children program.

Working with local physicians, MCO medical students have many opportunities: developing a clearer understanding of the relationship between social, cultural, and economic characteristics and health care issues; gaining an awareness of the health problems and special health risks of members of rural, underserved

populations; increasing their knowledge and developing their skills in providing community health education programs; and learning about services of northwest Ohio governmental agencies involved in health promotion and disease prevention.

Source: Jean H. Baird, Assistant Dean, Regional Programs and Director, AHEC Northeastern Ohio Universities College of Medicine, Rootstown, Ohio 44272

The Northeastern Ohio Universities College of Medicine has mandated a Primary Care Preceptorship in the late junior or early senior year on the clinical campuses of Akron, Canton, Youngstown, and the adjacent rural communities. More than one-third of the students select a rural site. The students participate fully in the physician's office practice, hospital and nursing home visits, and continuing education. Many students in rural communities reside with the preceptor or at the nearby community hospital for the month-long clinical experience.

The Northeastern Ohio Universities College of Medicine has expanded its continuing medical education program to include the Wooster Community Hospital, which serves Wooster physicians and nearby rural communities. The College offers consultation, faculty, and accredited programming based on medical staff needs assessment.

Source: Franklin R. Banks, Ph.D., Ohio State University, Department of Preventive Medicine, Starling Loving Hall, 320 West 10th Avenue, Columbus, Ohio 43210-1240

As part of its educational efforts, the **Ohio State University (OSU)College of Medicine** Department of Preventive Medicine in 1984 established a special training program in community medicine in Central Ohio for OSU medical students in conjunction with the OSU AHEC. A total of 84 medical students have participated in four-week assignments in one of eight communities in Central Ohio. In these communities students study the medical and health care delivery systems; patterns of medical care; the community hospital; the public health department; nursing home and extended care facilities; mental health treatment facilities; and other health agencies. Under the supervision of community physicians, students also observe and participate in clinical care activities, usually at the end of their first or second year of medical school.

Source: Donald B. Jentleson, Director for Academic Affairs, Wright State University, School of Medicine, P.O. Box 927, Dayton, Ohio 45401-0927

Wright State University School of Medicine's Department of Family Practice conducts a Summer Family Practice Preceptorship Program with financial support from the Area Health Education Center. Between 25 and 35 students are assigned to a rural family practitioner for four to six weeks between the first and second year of medical school.

Wright State's Small Community and Rural Medicine Club was developed to expose medical students early in their medical careers to the benefits and rewards of rural and small community medicine and to serve as a liaison between the community and the school to provide these areas with a source of physicians.

OKLAHOMA

Source: Edward N. Brandt, Jr., M.D., Ph.D., Executive Dean, The University of Oklahoma Health Sciences Center, P.O. Box 26901, Biomedical Sciences Building, Room 357, Oklahoma City, Oklahoma 73190-3042

The **University of Oklahoma College of Medicine** has a commitment to provide primary care physicians for the State of Oklahoma. Over 50 percent of Oklahoma's students enter primary care.

Recruitment efforts and the admissions process are geared to identify students with interest in primary care. The Admissions Board has representation from the six congressional districts of the state allowing practicing physicians from urban and rural communities to participate actively in the selection of Oklahoma's students. Recruitment trips involve the presentation of policies and procedures of the College supplemented by personal interaction with faculty and/or practitioners from that community.

Student organizations allow students time and opportunity to investigate primary care options as career choices. The Oklahoma State Medical Student Association has roundtable discussions that address rural health care and physician supply. The Student National Medical Association has health fairs that offer health screening to rural communities. The Family and Community Medicine Interest Group has 82 percent of Oklahoma's students as members and has arranged activities with the local Family Medicine Association and Oklahoma faculty.

A Medical Education and Community Orientation (MECO) program offers a unique opportunity for first-year medical students to experience the practice of medicine in hospital settings throughout Oklahoma. Over a period of four to ten weeks between the first and second years of medical school, students are exposed to patient care medicine as practiced by rural community physicians, the life-style of rural physicians, and the daily operations of clinics and smaller rural hospitals.

Rural Scholarships are offered by the state Physician Manpower Training Commission as financial assistance to students who want to practice in a rural community. For 1990-91, ten scholars were identified.

A required third-year family medicine clerkship is in its second year of existence. A required fourth-year experience for all medical students involves a one-month rotation at one of 28 sites in Oklahoma communities with populations of less than 10,000. A series of coordinated clinical experiences beginning in the first semester of the first year offer early exposure to patient care in primary care disciplines.

OREGON

Source: Julian S. Reinschmidt, M.D., Associate Dean, School of Medicine, Oregon Health Sciences University, 3181 S. W. Sam Jackson Park Road, L102, Portland, Oregon 97201-3098

The **Oregon Health Sciences University (OHSU)** inaugurated an Area Health Education Centers Program cooperative agreement in late 1990. The OHSU Family Medicine Residency Program has been expanded to allow for required rural rotations for all residents in the last two years of the program. These rotations began in July, 1991. Rural primary care rotations for medical

students are currently on an elective basis.

All third- and fourth-year students and all family practice residents attend didactic sessions on and have clinical experience with the migrant/seasonal worker culture in rural Oregon. Selected trainees have the opportunity for an additional, in-depth experience at a migrant health clinic. Faculty Development Workshops are held quarterly for rural family physicians who precept medical students and residents in their offices.

The Office of Rural Health is the statewide focal point for health advocacy to help ensure quality health care for rural Oregonians. As an unique state agency located in a university setting, the office defines and classifies rural hospitals; administers a rural practitioner tax credit program; conducts a physician recruitment program; offers technical assistance to rural communities, hospitals, and clinics; directs a grant program to foster development of primary care resources in rural communities; manages a loan repayment program; and is responsible for coordination of rural health policy development in the state. The agency also serves as a clearinghouse for rural health care information and resources and has been statutorily charged with developing new methods of health care delivery in rural areas.

PENNSYLVANIA

Source: Alan Jay Schwartz, M.D., M.S.Ed., Associate Dean for Academic Affairs, Professor of Anesthesiology and Pharmacology, Hahnemann University School of Medicine, Broad & Vine, Philadelphia, Pennsylvania 19102-1192

The **Gannon-Hahnemann** Family Medicine Program is a combined B.S.-M.D. program that currently requires a three-year undergraduate experience. It is designed to provide family practitioners to northwest Pennsylvania, a medically underserved area.

A new three-partner program has been initiated at Hahnemann University to address physician supply in rural areas. The introduction of the affiliation agreement highlights this partnership: "This agreement specifies the responsibilities of the Hahnemann University School of Medicine, the Guthrie Health Care System, and Wilkes University. . . . This cooperative effort is motivated by the national and . . . regional need for physicians interested in serving in rural and semirural health care delivery. . . .

"This program is not intended to train only family physicians, but rather to train all types of physicians that are needed to serve in rural and semirural health care settings."

Source: Howard K. Rabinowitz, M.D., Professor and Vice Chairman, Department of Family Medicine, Jefferson Medical College of Thomas Jefferson University, 1015 Walnut Street, Suite 401, Philadelphia, Pennsylvania 19107-5099

Jefferson Medical College of Thomas Jefferson University's Physician Shortage Area Program (PSAP) has been expanded to include a cooperative arrangement with six undergraduate institutions in the State of Pennsylvania: Allegheny College, Bucknell University, Franklin and Marshall College, Indiana University of Pennsylvania, Pennsylvania State University, and University of Scranton. The program is designed to increase the opportunities for young men and women to practice family medicine in the non-metropolitan communities of Pennsylvania.

Students with a non-urban background who are interested in practicing family medicine in a rural area or small town are encouraged to attend one of the six Cooperative Program schools for their

undergraduate education, and during their senior year to apply to the PSAP at Jefferson Medical College. The PSAP at Jefferson admits approximately 24 applicants each year.

Students who apply to Jefferson's PSAP must certify their intention (1) to participate in the Family Medicine Curriculum during their medical education at Jefferson Medical College, including a six-week clerkship in a rural area, and a senior outpatient subinternship in family medicine; (2) to complete a three-year family medicine residency; and (3) to agree to practice family medicine in an underserved rural area or small town.

Preference is given to Pennsylvania residents interested in this program, with highest priority given to those who live in a non-metropolitan area. Students who are accepted for admission to Jefferson Medical College in the PSAP will also be considered for preferential financial aid.

SOUTH CAROLINA

Source: G. Dean Cleghorn, Ed.D., Associate Dean for the South Carolina AHEC, Medical University of South Carolina, College of Medicine, 171 Ashley Avenue, Charleston, South Carolina 29435

In cooperation with the **Medical University of South Carolina (MUSC) College of Medicine and University of South Carolina (USC) School of Medicine**, the South Carolina AHEC conducts numerous efforts to address the problem of recruiting and retaining rural physicians.

1. One approach being used to address rural physician supply is the establishment of Rural Health Education and Training Centers. These centers provide a model rural practice setting for the training of primary care providers. Two centers began operation during 1991. They are located in areas that are medically underserved. In addition to meeting health care needs for the communities, the centers are designed as training sites for primary care residents and medical students.

2. The S.C. AHEC facilitates clinical rotations for junior and senior medical students in South Carolina community teaching hospitals across the state.

3. In association with MUSC and USC, AHEC and the South Carolina Academy of Family Physicians sponsor annually a four- to six-week summer rural preceptorship program for approximately 20 medical students interested in primary care.

4. The South Carolina Student Health Coalition each summer conducts two-week health screening clinics in two rural communities for a total of over 1,000 individuals.

5. The S.C. AHEC administers the National Health Service Corps Federal Loan Repayment Program, which provides loan repayment assistance to primary care providers choosing rural practice in underserved communities. Over 25 primary care physicians who have received assistance through this program are practicing in rural South Carolina.

6. The S.C. Rural Practice Incentive Grants are also administered by the S.C. AHEC. Nearly 60 physicians have received these grants for establishing rural practices. This program has focused on attracting third-year residents into rural practice.

7. The S.C. AHEC sponsors an annual Practice Opportunities Fair at which residents in training meet with representatives from hospitals, rural communities, and private practices.

8. The S.C. AHEC Minority Development Program maintains contact with over 2,000 promising young African American students who have expressed interest in medical and health careers. The program establishes contacts in over 75 percent of the high schools in the

state and provides ongoing assistance regarding health career information, academic skills development, college admissions assistance, and family support systems. Many of these students express interest in returning to practice in rural South Carolina.

SOUTH DAKOTA

Source: Robert C. Talley, M.D., Vice President/Dean, University of South Dakota School of Medicine, Vice President for Health Affairs, 2501 West 22nd Street, Sioux Falls, South Dakota 57117-5046

The **University of South Dakota (USD) School of Medicine** has produced a 10-minute television tape as a recruitment tool. A sophomore preceptorship student delivers the program to rural high schools throughout the state of South Dakota in the spring of each year.

In conjunction with the State Health Department, the School of Medicine has formed a statewide Office of Rural Health. This office is involved in recruitment of physicians for rural communities and in assessment of health care needs in rural communities. In a series of statewide meetings the Office of Rural Health has developed action priorities.

A major curricular change began June 1991. This innovation addresses 25 percent of the class, whose entire junior year consists of required clerkships taught in an ambulatory clinic where they will follow their patients. Small group discussion sessions with faculty facilitators will focus students on the patients' problems.

TENNESSEE

Source: Carol W. Jackson, R.N., M.P.A., Associate Director, AHEC Program of Tennessee, Meharry Medical College, 1005 Dr. D. B. Todd, Jr., Boulevard, Box 74-A, Nashville, Tennessee 37208

Meharry Medical College students are assigned to a three-week clinical preceptorship through family medicine in the junior year and a four-week clinical preceptorship through the Area Health Education Centers program in the senior year.

Both clerkships are required of all students and offered in affiliated community hospitals, office practices, and health centers located primarily in rural and urban underserved areas within the State of Tennessee. The focus is on ambulatory services in a comprehensive continuing health care program.

Source: Robert L. Summitt, M.D., Professor of Pediatrics and Anatomy, Dean, College of Medicine, University of Tennessee Memphis, Health Science Center, 800 Madison Avenue, Memphis, Tennessee 38163

In collaboration with the Tennessee Academy of Family Physicians, the **University of Tennessee College of Medicine** works on a statewide basis to train family physicians who can effectively provide comprehensive care in rural communities. Since 1977, four accredited University of Tennessee Family Practice Residency Training Programs have produced 310 graduates, 73 percent of whom are practicing in the state of Tennessee.

During 1990-91, a new third-year clerkship in Family Medicine was

implemented. The family medicine clerkship is equal in length and emphasis to all other clerkships in the third year of the curriculum. In one year, over 82 medical students have received training in rural communities. The University of Tennessee College of Medicine, class of 1991, chose family practice at a rate almost twice the national average.

The College of Medicine has embarked on a plan to increase its enrollment from 150 medical students per year to 160. The ten new positions will be offered to the ten members of the entering class who will commit to practicing in a designated underserved area. That commitment will be coupled with a waiver of all tuition for the four years of medical school for the ten applicants who are accepted into the program. Their commitment will be to a year-for-year payback of service in a designated underserved area.

TEXAS

Source: E. Jay Wheeler, M.D., Ph.D., Texas Tech University Health Sciences Center, School of Medicine/Office of Special Programs, Lubbock, Texas 79430

The Texas Tech University Health Sciences Center (TTUHSC) School of Medicine has as its major objectives the provision of quality medical education and the development of programs to meet the health care needs of the 108 counties of West Texas that comprise 49 percent of the land mass and 16 percent of the population of the total state. All TTUHSC medical students spend the first two years of the basic science curriculum in Lubbock. For the last two years one-third of each class is assigned to Amarillo, El Paso, or Lubbock. Each of these campuses also provides graduate training. The Odessa campus provides certain fourth-year electives and graduate training. The undergraduate medical education program requires each medical student to complete a six-week Family Medicine Clerkship in the third year. In addition, the Family Medicine Department operates a one-month Rural Family Medicine Elective Preceptorship Program for fourth-year students.

The TTUHSC School of Medicine has developed the following programs: (1) the Texas Tech MEDNET Telecommunications Demonstration Project; (2) the TTUHSC Department of Family Medicine Rural Medicine Tract, a two-year, longitudinal elective experience available to second- and third-year residents has as its primary site of the training the Shallowater (Texas) Family Practice Center; residents may also elect to spend up to one month in the second or third year at a distant rural site; and (3) the Binational Community-based System for Primary Care and Multi-Disciplinary Health Professional Education—a W. K. Kellogg Foundation-funded program to develop, operate, and sustain a multisite, community- and family-centered system for preventive, primary, and continuity referral health care in Juarez, Mexico, which provides training for medical students and primary care residents at both TTUHSC—El Paso, and the Universidad Autónoma de Ciudad Juarez.

Source: Ross, William F., and Snell, Laura M. Family Practice—Alive and Well at Southwestern Medical School. *Dallas Med. J.* (April 1991):155-156.

The Department of Family Practice and Community Medicine of the University of Texas (UT) Southwestern Medical Center at Dallas has as its primary mission developing comprehensive medical education programs in family practice. The department has five affiliated three-year family residency programs with a total of 126 residency positions. Approximately 42 family

physicians are graduated each year from the department's affiliated programs with over 80 percent of the graduates practicing medicine in Texas, many in rural areas.

First- and second-year students at Southwestern Medical School learn about the discipline of family practice in several ways: (1) A summer preclinical preceptorship available through the Texas Statewide Preceptorship Program has attracted annually 15-20 students for four weeks with either a Texas family physician or at a Texas family practice residency program; (2) The Family Practice Student Association has monthly meetings; and (3) The Dallas Chapter of the Texas Academy of Family Physicians offers a mentor program for Southwestern medical students interested in family practice.

A required four-week clerkship in family practice in the junior year annually provides ambulatory clinical experiences to 200 medical students. Medical students can also take a four-week preceptorship in their senior year to learn more about family practice. This course annually attracts approximately half the senior class. An average of 10 percent of each year's UT Southwestern graduating class currently chooses a residency in family practice.

Source: William McGanity, M.D., Chairman, U. T. System Valley/Border Health Services Task Force, U.T. Medical Branch at Galveston, Galveston, Texas 77550-2774

The **University of Texas (UT) System Valley/Border Health Services** Task Force was formed in August 1988 to serve as an advisory body to the University of Texas System Chancellor's Office. The group consists of representatives of five U.T. System health science institutions, U.T. Pan American, U.T. El Paso, and selected schools at U.T. Austin. Liaison relationships have been established with state and federal health-related education and service agencies.

The mission of the U. T. System Valley/Border Health Services Task Force is to advise, inform, and recommend to the U. T. System Chancellor's Office; to maintain an inventory; and to coordinate, cooperate, and integrate U. T. System health-related education activities and technical assistance focused in the Valley/Border area.

Three significant initiatives are underway as of October 1991:

1. The Health Education and Training Center Alliance of Texas (HETCAT), is an alliance project of all eight Texas medical schools that is focused on the medically underserved areas within 200 miles of the U.S.-Mexican Border from Brownsville to El Paso. The HETCAT is evaluating in three subregions the needs for health care personnel, assisting in the planning, development, and implementation of training programs to meet the needs identified by the community itself.

2. The U. T. Health Science Center at San Antonio has established the Lower Rio Grande Valley/South Texas Area Health Education Center (AHEC), initially serving three medically underserved counties. Programs in operation are the following: assessing the health manpower needs of the underserved areas; encouraging health professionals, students, and postgraduates/residents in health facilities in the targeted region and recruiting them to return and practice in the South Texas area; enhancing the Family Practice Residency Program in McAllen; developing a circuit library system that expands and assists local hospitals and clinics; and assisting in the awareness, preparation, and recruitment of local students for the health professions.

3. The U.T. System Valley/Border Health Coordinators Office (VHCO) has been established at the U.T. Pan American Campus at Edinburg, Texas. The Office, its directors, and staff provide support, coordination, and liaison services to all 14 of the University of Texas System components, academic

and health-related education, service, and research activities operational from Brownsville to El Paso.

The goals of the Valley Health Coordination Office are the following: (1) establishing and maintaining a central point of coordination for system-wide health professional educational programs, health delivery services, and research activities within the Valley/Border Area; (2) improving the supply, distribution, quality, and efficiency of personnel providing health services in the Valley/Border Area; (3) participating with local Valley/Border health-related resources in their community health priorities planning; (4) implementing their health services programs for their populations; and, (5) sponsoring health promotion and disease prevention activities in the Valley/Border Area.

The U. T. Medical Branch at Galveston, through an interagency contract with U. T. Pan American, provides the financial support to operate and staff the Valley Health Coordination Office.

Source: Leonard G. Paul, M.D., Professor and Chairman, Department of Family Practice, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, Texas, 78284-7794

The University of Texas Health Science Center at San Antonio's Department of Family Practice began its third-year clerkship in July 1990. Clerkships are located in three family practice sites: San Antonio, McAllen, and Corpus Christi, which are the sites of the Family Practice Residency Programs. The majority of the students have as their out-patient facility the Family Health Center of the Department of Family Practice in San Antonio. Students at all three sites receive 40 percent of their experience in the outpatient facility of the Residency Program of Family Practice, 20 percent in an office of a private family physician acting as preceptor, 20 percent in the nursing home for geriatrics, and 20 percent in conferences and study time.

A one-month rural preceptorship elective has been added in the fourth year. Students make hospital rounds, attend hospital meetings, and accompany the preceptors on house calls.

Source: Ciro V. Sumaya, M.D., M.P.H.T.M., Director, Area Health Education Center, Director, South Texas Health Research Center, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, Texas 78284-7790

The University of Texas Health Science Center (UTHSC) at San Antonio established an Area Health Education Center (AHEC) covering 28 counties of South Texas, approximately 80 percent of which are rural. This program establishes linkages between UTHSC San Antonio, other states and health/educational institutions, and rural or underserved communities of South Texas.

The AHEC is establishing medical student clerkships and electives at training sites located in Community/Migrant Health Centers, Family Medical Centers, Public Health Clinics, Veteran Administration Clinics, and other health facilities in the South Texas area. Residency training programs in selected disciplines such as family practice, psychiatry, and pediatrics will be established or enhanced in this geographic area.

The South Texas Health Research Center at the University of Texas Health Science Center in San Antonio has as its mission improving the overall health status and health services in South Texas in general with special focus on the Hispanic population of that region.

Research activities are in basic, clinical, and epidemiological areas; in health services and policy development; design, implementation, and evaluation of community health promotions; and development of health professional education and career opportunities.

Source: Siegel, Claudia H. The Texas Family Practice Residency Program: A Profile. *Texas Medicine* 86(May 1990):65-68.

The statewide Family Practice Residency Program has made a significant contribution to Texas's primary care physician supply and distribution over the past 12 years. During that time, the number of family practice residency programs in Texas has grown from 12 to 25, with 1,174 graduates as of September 1988. This article discusses the program's origins, administration, effectiveness, and future.

Source: Claudia H. Siegel, M.A., M.P.A., Director of Medical Programs, Office of the Deputy Commissioner, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711

The Texas Legislature mandated in 1989 that all Texas medical schools incorporate a clerkship in family practice in the third year. Beginning in 1990, the schools incorporated third-year clerkships in family practice ranging from four to six weeks in length. All clerkships involve objective evaluation and standardized curricula. The clerkship is being monitored to determine its effect on the number of medical school graduates choosing family practice and other primary care specialties and to determine whether it improves attitudes toward family medicine and primary care within the medical school environment.

Legislation passed in 1989 also requires all family practice residency programs to offer a one-month rotation through a rural setting. The mandate is being fulfilled by providing a wide range of sites throughout the state in non-urbanized communities of under 25,000.

VIRGINIA

Source: Cheryl Harrison-Davidson, M.Div., Medical Education Coordinator, Department of Family and Community Medicine, Eastern Virginia Medical School, P.O. Box 1980, Norfolk, Virginia 23501

The Department of Family and Community Medicine historically has committed itself to providing opportunities for students to work in medically underserved areas throughout their four years at **Eastern Virginia Medical School (EVMS)**. EVMS is completing the second year of a three-year grant whose primary objective has been to maintain and strengthen the predoctoral curriculum with an emphasis on underserved site development. Electives related to rural/underserved opportunities for 1991-92 are as follows:

1. The Family Practice Preceptorship is offered to from one to six fourth-year students. The students spend from two to four weeks with an approved community preceptor or in an approved family medicine residency. Past experiences have included rural sites in Virginia and the Indian Health Service. Students take care of patients under supervision and participate in educational activities.

2. The Apprenticeship in Family Medicine, for from one to five first- and second-year students, a six-hour course seminar is of six to eight weeks duration.

Through seminars, reading, and direct observation of family physician preceptors, the student develops an accurate understanding of family medicine as a discipline and potential career choice.

3. The course in Rural Medicine, for third- and fourth- year students, can be modified as a first- or second-year elective. Students work with a family physician in a rural primary care office. Students' efforts are 90 percent outpatient and 10 percent study/reading time.

4. The Migrant Worker elective is designed to provide an in-depth experience in rural community medicine. The sites are DelMarva Rural Ministries and other Eastern Shore health facilities providing services for migrant workers. Students' efforts are 80 percent patient care and 20 percent health education. Students are able (1) to identify special health conditions within the migrant labor population; (2) to discuss the delivery of medical care in a rural area without direct access to hospital services; (3) to identify the nutritional factors in the migrant population that contribute to their health problems; (4) to utilize a multidisciplinary team approach to health care management; (5) to recognize the environment, family situations, and social structures as important contributions to the health status of an individual; (6) to describe the contribution poverty plays in the distribution of infections and chronic diseases; and (7) to demonstrate health education skills.

Source: R. B. Young, M.D., Associate Dean, Continuing Medical Education & Alumni Relations, Medical College of Virginia, School of Medicine, Box 48, MCV Station, Richmond, Virginia 23298-0048

Through its Office of Continuing Medical Education (OCME) the **Medical College of Virginia (MCV)** currently has several efforts addressing the problem of physician supply in rural areas. Among them are the following:

1. The Virginia Hospital Television Network (VHTN) was organized in the fall of 1987 utilizing interactive educational technology and bringing continuing education directly to the community hospital. Services include satellite broadcast of television programs for health care professionals and OCME staff assisting community hospitals with effective utilization of television service. Over 200 hospitals participate in selected programs. The VHTN also develops and coordinates Clinical Interactive Audioconferences of particular interest to Virginia hospitals.

2. In the Affiliate Hospital Program, OCME works with Directors of Medical Education at 20 community hospitals statewide and arranges for MCV faculty to travel to hospitals to lecture at regularly scheduled medical staff meetings and continuing education conferences.

3. Clinical workshops to explore a specific clinical topic or a group of closely related topics are half-day and full-day sessions for groups of five to twenty participants.

4. Theresa A. Thomas Educational Resources Centers (ERCs) with computer linkages to health care national databases, such as the National Library of Medicine, are increasingly utilized by rural hospital staffs.

5. A pilot program has been initiated that will allow rural physicians to access information regarding their hospitalized patients via the computer-based Hospital Information System in MCV Hospitals.

VIRGINIA *continues on following page*

Source: Philbrick, John T., et. al. Restoring Balance to Internal Medicine Training: The Case for the Teaching Office Practice. *Am. J. Med. Sci.* 299(1990):43-49.

"Medical residents require an experience beyond the tertiary care hospital to understand many aspects of contemporary medical practice and to make informed career choices. To provide this balanced training, the **University of Virginia** has operated for 10 years an internal medicine teaching office practice to provide an outpatient experience similar to private practice. It allows residents to work closely with general internal medicine faculty and introduces them to the knowledge and skills necessary to establish and manage a successful practice. The curriculum of the 10-week rotation includes patient care in the office and by telephone, nursing home and home visits, tutorials and seminars on primary care and office management topics, and training in the use of microcomputers. A survey of 46 (92 percent) of the first 50 residents completing the rotation revealed that the content of the rotation was valuable, the rotation substantially influenced career choices, and the rotation helped provide a balanced view of internal medicine practice."

WASHINGTON

Source: Joan Kelday, WAMI Regional Programs, School of Medicine, Office of the Dean, XF-01 University of Washington, Seattle, Washington 98195

1. Kelday, Joan. *University of Washington School of Medicine: A Regionalized Institution Serving Washington, Alaska, Montana and Idaho*. Unpublished. March 1989. 10 pp.

In 1949 the **University of Washington School of Medicine's** first class of medical students spent a month or more of their clinical training with physicians in parts of Washington and Alaska, learning about lifestyles and the practice of medicine in small communities. By 1970, the medical school had established the federally funded Washington/Alaska Regional Medical Program, which emphasized continuing education and creating new links with practitioners, professional organizations, and health care agencies in the two states.

The school founded a Department of Family Medicine and regionalized the medical curriculum through the Washington, Alaska, Montana, Idaho (WAMI) Regional Medical Education Program. Relationships were formed between the school and universities, boards of higher education, and legislatures in the states of Montana and Idaho, as well as Alaska, none of which has a school of medicine. The school took another step in regionalization in 1985 when it assumed sponsorship of an Area Health Education Center (AHEC) Program in the WAMI states. The author describes characteristics of the region, and the WAMI educational programs in undergraduate, graduate, and continuing medical education. She also discusses other special resources, such as the Northwest Geriatric Education Center Program.

2. University of Washington. Rural High School Students Introduced to Medicine. *University Week* (April 19, 1990):7.

The WAMI program is trying new methods to recruit students from rural areas into medicine. In the summer of 1990 six top students, selected from nominations from 200 rural high schools participated in a week of total immersion in the medical field: with physicians on rounds and in a research lab, a large hospital, and a small rural hospital. Besides group activities, the students interacted one-on-one with researchers, medical educators, and health care providers. In addition, the students learned strategies on getting into and succeeding in college. Each high school

student had two WAMI medical students as his or her mentors.

3. Myers, Wayne W. WAMI AHEC Program. *The National AHEC Bulletin* 8(Fall 1990):38,41.

The **University of Washington's WAMI AHEC** system came into being in 1985. The system engages in distinctly nontraditional AHEC activities as well as those associated with the national program since its inception.

The less traditional efforts aim to strengthen the governance and management of rural community hospitals and health care systems through a process developed by the University of Washington Department of Family Medicine in a grant from the W. K. Kellogg Foundation. This work, currently funded in part by the Northwest Area Foundation and by the communities themselves, is under way in 20 small towns across the WAMI region.

Results the communities achieve vary. Rather typically, one town with 1,000 residents and the sole hospital within 60 miles has recruited a physician, achieved preferred provider status, produced the hospital's first annual report and marketing plan, purchased a pharmacy, submitted certificate of need for nursing home beds, and improved relations with the nearby Indian Health Service. The hospital is now offering respiratory therapy in patients' homes, negotiating scope of services, recruiting nurses, and beginning long-range planning.

A community's ability to retain and attract health personnel improves as the local health care delivery system stabilizes. For reinforcement, the AHECs offer additional educational activities. Seward, Alaska, will host third-year medical students on rotation from family medicine clerkships in Anchorage. Ellensburg, Washington, has a resident in family medicine for two years through a new rural residency training track. Physicians in Ronan, Montana, in the summer of 1989 served as preceptors for a first-year medical student. AHEC-community relationships formed during the stabilizing process facilitate the targeting of supportive educational programs.

Five hundred health professions students and 2,200 practitioners took part in 1989 in other more customary AHEC programs. Almost half of the practitioners attended educational events given in communities with fewer than 25,000 people.

The AHECs are also taking a leading role in promoting regional and statewide discussion on rural health issues.

4. Lyons, Stephen. Where Have All the Doctors Gone? *Idaho the University* (Spring 1991):7-11.

Idaho has the lowest number of physicians per capita in the nation and the oldest average age of practicing physicians. Idaho urgently needs 150 doctors. Rural communities will have to recruit actively to maintain health care access for their residents.

"The WAMI program guarantees 15 seats for qualified Idaho residents at the **University of Washington School of Medicine**. Those students take their first year of medical studies at the University of Idaho then continue at the UW during the second year, with third and fourth years devoted to clinical clerkships. Idaho medical students may do these clerkships in Boise or Pocatello with the hope that these students will want to come back to Idaho and practice."

Other WAMI incentives include fellowships for medical students to practice in small towns and a Medical Scholars Program to bring high school students to the University of Idaho campus in the summer to work with local health care practitioners. The Family Practice Medical Center has launched a See Idaho Week for its medical residents in their second year of training.

WASHINGTON *continues on following page*

Source: Laurie Iverson, M.A., A.R.N.P., Executive Director, Western Washington Area Health Education Center, 2033 Sixth Avenue, 405 United Airlines Building, Seattle, Washington 98121

The Rural/Underserved Opportunities Program (R/UOP) is a collaborative effort of the Western and Eastern Washington AHECs, the Family Health Foundation, the Washington Academy of Family Physicians, and the **University of Washington School of Medicine**, WAMI site coordinators, Department of Family Medicine, and the Dean's office. R/UOP provides an opportunity for students between their first and second years of medical school to be placed with preceptors in rural or urban underserved sites.

Begun in 1991, the Tacoma Fellowship in Rural Family Medicine is a training experience designed to augment the family physician's training before entering rural practice. Tacoma Family Medicine (TFM) is a community-based family practice residency affiliated with the University of Washington School of Medicine.

The one-year TFM fellowship includes six months of intensive obstetrical training, five months of electives in almost any medical or surgical specialty or subspecialty, and one month at a rural site working with a rural physician.

Two-thirds of TFM's graduates are in practice in towns of less than 25,000. Almost half are in towns of less than 10,000.

WEST VIRGINIA

Source: Lamont D. Nottingham, M.P.H., Ed.D., Assistant Director, Central AHEC Office and Continuing Education Outreach, West Virginia University Health Sciences Center—Charleston Division, 3110 MacCorkle Ave., S.E., Charleston, West Virginia 25304

West Virginia University Health Science Center—Charleston Division, Marshall University School of Medicine and the West Virginia School of Osteopathic Medicine have been awarded a cooperative agreement with the Bureau of Health Professions. The purpose of the project is the establishment of an health education training center (HETC) to help meet the health needs of residents in a five-county region having less access to health care than people in other parts of the state.

The establishment of the Southern West Virginia HETC in October 1990 provides an opportunity for West Virginia to develop a regional consortium model for training medical and health professions students within a rural Appalachian environment. The first rotation of 15 medical and health sciences students is scheduled for the summer of 1992.

Source: R. John C. Pearson, M.B., M.P.H., Professor and Chairman, Department of Community Medicine, West Virginia University—Morgantown School of Medicine Health Sciences Center South, Morgantown, West Virginia 26506

West Virginia University (WVU)-Morgantown School of Medicine has a variety of approaches to help West Virginia meet its need for rural primary care:

1. WVU helped local communities set up 62 new primary care clinics by organizing community efforts, writing grant proposals, recruiting physicians, and improving the skills of the administrators.

2. WVU has a visiting clinician program in which 42 rural physicians participate regularly in the teaching of

medical students and in continuing medical education (CME) at WVU, one day a month.

3. Through a Medical Access and Referral Service program rural physicians can get advice by telephone from specialists to help treat their patients; the usual turn-around time is five to ten minutes. Other toll-free telephone communications to WVU are available for poison control and for cancer information.

4. WVU won the grant to set up the first six PATCH sites (Planned Approach to Community Health), which has expanded to nine. WVU also established, and for a long time staffed, the State Health Education Consortium, the meeting ground for health educators in the state. WVU also participated in the establishment of the state Wellness Council, and recently won a HETC grant for five southern counties.

5. WVU Hospital has contracts to assist five rural hospitals in a variety of ways.

6. A new program that has started with only one hospital uses visual telephone communication to allow WVU specialists to examine patients at a distance. CME is conducted at 28 hospitals and clinics statewide.

7. A W. K. Kellogg Foundation grant, a National Cancer Institute grant, and a Centers for Disease Control grant fund outreach programs in rural counties for breast and cervix screening and school health screenings. One- to three-month rural practice elective opportunities for medical students are also available at the end of the first year and in the fourth year.

WISCONSIN

Source: Charles E. Gessert, M.D., Co-Director, Wisconsin AHEC System, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226

The Wisconsin Area Health Education Center (AHEC) System was developed to improve access to needed primary health care services in the State's rural and urban underserved communities. The AHEC project is administered as an equal partnership between the **Medical College of Wisconsin** and the **University of Wisconsin Medical School**.

The goals of the Wisconsin AHEC System are (1) to expand the role of the State's health professions educational programs in rural and urban underserved communities; and (2) to improve the supply and geographic and cultural distribution of health care professionals with the skills necessary to meet Wisconsin's statewide needs.

Through cooperative campus/community planning and implementation of programs, the Wisconsin AHEC System (1) stimulates student interest and effectiveness in working with underserved populations/communities; (2) provides communities with opportunities to plan and implement educational programs to help meet health care needs; (3) supports health care providers in underserved areas through linkages with campuses, continuing education, and other programs; (4) and develops new, multidisciplinary, client-oriented educational experiences.

Three of Wisconsin's local AHECs are addressing problems of health care issues and resources in rural areas:

1. In northern Wisconsin the AHEC serves a 38-county area that is largely rural and far from many of the major health professions education campuses. In this area of Wisconsin, health professionals are retiring and curtailing their practices at a rate which far exceeds the influx of new providers. As a result, critical gaps have appeared in health care in the Northern Wisconsin AHEC area.

2. In southwest Wisconsin, the AHEC serves 18 largely rural counties, where geographic isolation is exacerbated by a landscape of hills, rivers, and uneven countryside. This area of Wisconsin is

characterized by small rural hospitals and an aging provider population.

3. In southeast Wisconsin, the AHEC serves 15 largely agricultural counties spread out between Lake Michigan and the Fox River Valley, an area of the state characterized by many small- and medium-sized hospitals, persistent and growing shortages of nurses and allied health personnel, and an aging primary care provider population.

Both the University of Wisconsin Medical School and the Medical College of Wisconsin have made commitments to establish new, required ambulatory third-year medical student clerkships. All AHEC target areas have one or more family practice programs.

Source: John E. Midtling, M.D., M.S., Chairman, Department of Family Medicine, Medical College of Wisconsin 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226

The Medical College of Wisconsin Department of Family Medicine describes its involvement in the following rural health initiatives:

Programs for undergraduate medical students include the Family Practice Student Association, which currently has 136 medical student members who discuss topics relating to rural health issues. In the summer of 1991, 14 second-year medical students were placed with rural practitioners through the Rural Summer Externship program. During the 1990-91 academic year 22 third-year students were placed with rural practitioners.

In graduate medical education, rural rotations are available to 92 resident physicians. The Indian Health Service rotation, developed at Menominee Tribal Health Clinic in Shawano, Wisconsin, is being implemented during the 1991-92 academic year. The Kenosha and Waukesha programs have been highly successful in placing graduates in rural Wisconsin. Of those staying in Wisconsin more than 80 percent have located in rural areas. One-third of the 236 MCW graduates between 1979 and 1989, have located in Wisconsin communities of under 10,000 population.

The Medical College of Wisconsin Department of Family Medicine had a lead role in the development of the statewide AHEC system. The Southeastern Wisconsin Rural AHEC will expand and fund the development of student and resident rural rotations as well as support the rural practitioner through educational linkages to the Medical College of Wisconsin.

APPENDIX 1

RURAL TRAINING OPPORTUNITIES APRIL 1991

STATE	INSTITUTION/SITES
AL	Carraway Methodist Medical Ctr Birmingham
	U of South Alabama
AZ	Good Samaritan Regional Med Ctr Phoenix
AK	U of Arkansas for Med Sciences Fayetteville
CA	St Francis/USC
	U of California SF-Fresno
CO	Commission on Family Medicine Denver
	St. Mary's Fam Practice Residency/U of CO
	U of Colorado
GA	Floyd Medical Center Rome
	Medical Center of Central GA/Mercer U.
IL	Carbondale Fam Practice Ctr/SIUC School Med Carle Foundation Hosp/U of I-Col. Med Urbana-Champaign
	Decatur Memorial Hosp/St. Mary's/SIU Sch Med
	U of I Col Med Peoria/Methodist Med Ctr
IN	St. Mary's Medical Center Evansville
	Memorial Hospital South Bend
	Union Hospital Terre Haute
KS	Smoky Hill Fam Practice Residency U K Sch Med-Wichita/Salina
	U of Kansas School of Medicine
KY	U of Kentucky Col Med
	U of Louisville Sch Med
	Trover Clinic Madisonville
LA	Louisiana State U. Medical Center
	LSU Sch Med-Shreveport

NR = No Response

PROGRAMS	LENGTH	ELECTIVE/ REQUIRED
Resident/Preceptorship	1 mo	Elective
Resident/Preceptorship	NR	NR
Advanced/Preceptorship	4 wk	NR
Resident/Preceptorship	11-12 mos	Required
4th-yr Student/Preceptorship	4 wks	Elective
PGY II or III	1-2 mos	Elective
Student/Resident	NR	Elective
Resident/Preceptorship	1 mo	Required
4th-yr Student	1 mo	NR
Student/Preceptorship	NR	NR
Resident/Preceptorship	1 mo	Elective
PGY II/Preceptorship	4 wks	Required
PGY III/Preceptorship	1 mo	Elective
Student/Preceptorship	2 or 4 wks	NR
Resident	NR	NR
Resident	3 yrs	NR
Resident	3 mos	Elective
Resident/Preceptorship	200 hrs	NR
PGY II & III	2 mos	Required
Resident/Preceptorship	NR	Elective
Jr & Sr Student	NR	Elective
Resident	NR	NR
Student	NR	Elective
Sr Student	1 mo	Required
Resident/Preceptorship	NR	NR
Student/Clerkship	NR	NR
Resident	1 mo	NR
Jr Student	1 mo	NR
PGY II/Preceptorship	1 mo	NR
Student	1 mo	Elective
Jr Student	4 wks	Elective
Sr Student/Preceptorship	4 wks	Required
Sr Student/Preceptorship	4 weeks	Elective
Jr or Sr Student	4-8 wks	Elective

Source: Working Group of Teachers of Rural Family Medicine of the Society of Teachers of Family Medicine. Produced with permission. Summary prepared by Debbie Martin July 26, 1991.

STATE	INSTITUTION/SITES
ME	Eastern Maine Medical Center
MA	U of Massachusetts Med Center
MI	St. Mary's Hospital Grand Rapids
	Michigan State U Kalamazoo Ctr for Med Studies
MN	Duluth Family Practice Residency Program
	Mayo Clinic
	St Paul-Ramsey Medical Center
MS	U of Mississippi Med Ctr
MO	Cox Medical Centers Springfield
	Deaconess Hospital/St. Louis Central Ozarks Med Center/Richland
	U of Missouri-Columbia Sch Med
NB	Creighton University
	U of Nebraska Medical Center Lincoln, Creighton, 60 Rural Sites Good Samaritan Hosp Kearney Good Samaritan Hosp Gen Surg Kearney
NV	U of Nevada School of Medicine
NH	Dartmouth Medical School
NM	U of New Mexico School of Medicine
	Santa Fe-La Familia Med Ctr/U NM Sch Med
NY	SUNY at Buffalo Sch Med
	SUNY Health Science Center, Syracuse
NC	East Carolina Sch of Med Bethel Family Practice Ctr/Williamstown
	U of North Carolina School of Medicine Mars Hill

PROGRAMS	LENGTH	ELECTIVE/ REQUIRED
PGY II/Preceptorship	6-7 wks	Required
PGY III/Preceptorship	4-8 wks	Elective
Resident	NR	NR
1st, 2nd, 4th yr-Student	NR	Elective
3rd-yr Student/Clerkship	NR	Required
PGY III	1 mo	Required
PGY III	1 mo	Elective
Resident/Preceptorship	1 mo	NR
Sr Student	1 mo	Elective
PGY II/Preceptorship	1 mo	Required
Resident	1 mo	Required
Sr Student/Preceptorship	1 mo	Elective
Sr Student/Clerkship	1 mo	Elective
PGY II & III/Preceptorship	4 wks	Required
Resident/Preceptorship	2-4 wks	Elective
Resident/Preceptorship	2 yrs	Required
Sr Student	NR	Elective
Sr Student/Preceptorship	NR	NR
PGY II & III/Preceptorship	2 mos	Required
Jr Sr Student/Preceptorship	8 wks	Required
PGY III	1 mo	Elective
PGY I & II/Preceptorship	2 mos	Elective
Sr Student	1 mo	Required
PGY III	1 mo	Elective
Student/Preceptorship & Research Assistantship	6-12 wks	Elective
3rd- or 4th-yr Student/Clerkship	7 wks	Required
4th-yr Student	2-8 wks	Elective
4th-yr Student/Preceptorship	1 mo	Required
1st-yr Student/Preceptorship	16 wks	Required
Resident	NR	NR
Resident	NR	NR
3rd-yr Student/Preceptorship	9 mos	Elective
Resident/Preceptorship	1 mo	NR
Resident/Preceptorship	1 mo	NR
Student	4 wks	Elective

STATE	INSTITUTION/SITES
ND	Minot Fam Practice Residency U North Dakota School of Medicine
OH	U of Cincinnati College of Medicine
	Grant Medical Center Columbus
	Ohio State University Col of Med
OK	Enid Family Medicine/U of OK Col Med
	U of Oklahoma College of Medicine
OR	Oregon Health Sciences University
PA	Good Samaritan Hospital Penn State University
	Hamot Medical Center Erie
	Jefferson Medical College
	Lancaster General Hospital Lancaster/Quarryville
SC	Anderson Family Practice Center Medical U of South Carolina
	Medical U of South Carolina The Hampton Community Health Fdn
	Self Memorial Hospital Greenwood
SD	Sioux Falls Family Practice Residency
	U of South Dakota School of Medicine
TN	East Tennessee State U Col of Med
	U of Tennessee Col of Med

PROGRAMS	LENGTH	ELECTIVE/ REQUIRED
Resident/Preceptorship	NR	NR
Student/Preceptorship	1 mo	Elective
PGY II & III	1 mo	Elective
3rd & 4th-yr Student/Preceptorship	1 mo	NR
Resident	NR	NR
4th-yr Student/Preceptorship	1 mo	Required
PGY II & III	NR	Required
3rd-yr Student	NR	Required
Resident/Preceptorship	NR	Elective
4th-yr Student/Preceptorship	4 wks	NR
Student/Preceptorship	4-6 wks	NR
Sr Student/Preceptorship	6 wks	Elective
Jr Student/Preceptorship	NR	Required
Resident/Preceptorship		NR
4th-yr Student	1 mo	Elective
Resident/Preceptorship	4-6 wks	Elective
3rd-yr Student	NR	Required
PGY II & III	1 mo	NR
All levels	2 wks	Elective
PGY III/Preceptorship	1 mo	Required
PGY II & III	1 mo	Elective
Soph Student/Clerkship	1 mo	Required
Jr Student/Clerkship	4 wks	Required
Student/Preceptorship	NR	NR
Resident	1 mo	NR
PGY IV/Fellowship	NR	NR
Post-resident Minifellowship	18-30 days	NR
Student/Clerkship	4-12 wks	NR

STATE	INSTITUTION/SITES
TX	Baylor College of Medicine
	TX Acad of Fam Physicians & Coordinating Bd
	TX Coordinating Bd & Statewide Preceptorship
	TX Higher Ed Coordinating Board
	Texas Tech U Health Sciences Center
	UT Health Sciences Center at San Antonio
	UT Southwestern Medical Center McLennan County Fam Practice Residency
UT	U of Utah School of Medicine
VA	Blackstone Fam Practice Ctr Medical College of VA
	Lynchburg Family Practice Residency
	Portsmouth Family Medicine Residency Prg Eastern VA Medical School
WA	Tacoma Family Medicine Practice Residency
	U of Washington Sch of Med
WV	Marshall University School of Medicine
WI	Eau Claire Family Practice Residency Prg
	St. Francis-Mayo Family Practice
	St. Luke's Medical Center
	U of Wisconsin Medical School Wausau Hospital Center Antigo, Marshfield
WY	U of Wyoming Cheyenne

NR = No Response

Source: Working Group of Teachers of Rural Family Medicine of the Society of Teachers of Family Medicine. Produced with permission. Summary prepared by Debbie Martin July 26, 1991.

PROGRAMS	LENGTH	ELECTIVE/ REQUIRED
PGY II/Preceptorship	1 mo	Required
PGY III/Preceptorship	1 mo	Elective
Student/Preceptorship	1 mo	NR
Student	1 mo	Elective
PGY II/Preceptorship	1 mo	Elective
PGY II & III	1 mo	Elective
Student/Preceptorship	4 wks	NR
PGY II & III	2 yrs	Elective
PGY II & III	1 mo	Elective
Sr Student/Preceptorship	NR	Elective
Resident/Preceptorship	NR	NR
PGY II & III	1 mo	Elective
Student/Preceptorship	NR	NR
Resident/Preceptorship	3 mos	Required
Resident/Preceptorship	2 yrs	NR
4th-yr Student	2-4 wks	Elective
3rd-yr Student/Clerkship	4 wks	Required
PGY II	1 mo	Required
PGY III	1 mo	Required
PGY IV/Fellowship	1 yr	NR
3rd & 4th-yr Student/Clerkship	NR	Elective
3rd & 4th-yr Student/Preceptorship	NR	Elective
Resident	NR	NR
4th-yr Student	NR	Elective
Resident	1 mo	Elective
PGY II & III/Preceptorship	1 mo	Elective
4th-yr Student	NR	Elective
PGY II or III/Preceptorship	1 mo	Elective
Resident	NR	NR
3rd & 4th-yr Student	1 mo	NR
PGY II/Preceptorship	1 mo	NR
PGY II & III/Preceptorship	1 mo	Required

Representative Frank Tejeda
Questions Submitted for the Record
Through October 20, 1993 Letter
Department of Veterans Affairs
Subcommittee on Hospitals and Health Care

October 14, 1993

In my district in South Texas, several counties have no hospitals or doctors. You testified that VA would provide care to veterans in these areas through expansion of outpatient clinics and contract agreements.

Question: I would appreciate if you would provide me with more details on the care for veterans and his or her dependents in such rural and under served areas. Also, what is the VA's timetable for expansion into these areas, and how does the VA intend to finance the expansion prior to receiving reimbursements from the regional health alliance?

Answer: VA's planning for implementation of national health reform is still in early stages of development; however, the President's proposal would authorize VA to treat a veteran's dependents. However, just as we had done earlier in south Texas (vis-a-vis the establishment of several satellite and community-based clinics), the San Antonio VAMC is to examine the implementation of an outreach and primary care clinic program which would result in the activation of a number of small VA-staffed or VA-contract facilities, serving both veterans and their dependents, throughout south Texas (e.g., Brownsville, Eagle Pass, etc.).

I want to commend you on your response concerning the hiring of personnel for new outpatient clinics versus shifting scarce personnel from overburdened VA hospitals. In San Antonio, it is critical that we do not shift personnel from Audie L. Murphy Memorial Veterans Hospital which serves over 41 counties in south Texas with a veterans population of approximately 300,000.

Question: In addition, I share your support for updating VA hospitals to meet the basic conveniences offered in the private sector. You are correct that the VA must upgrade to compete with hospitals that are comparable to "Hilton Hotels." I would like to know how the VA intends to finance this needed upgrade.

Answer: VA expects that the proposed Health Security Act will include a Veterans Health Care Investment Fund to assist the VA in preparing for National Health Care Reform. The funds proposed, $3.3 billion over a three year period, would help support infrastructure improvements to upgrade VA's health care services. Although it will be important to make the VA attractive to potential veteran enrollees, upgrading structures to become "Hilton Hotels" in appearance may not always be prudent or consistent with the goals of providing quality health care services to veterans.

In San Antonio, the VA has strong affiliations and sharing agreements with The University of Texas Health Sciences Center, Bexar County Medical Center Hospital, Brooke Army Medical Center, and Wilford Hall USAF Medical Center resulting in considerable cost savings to the VA. The VA also benefits from the excellent medical research carried out by the affiliated facilities. An excellent example of this cooperation is the new Research Imaging Center in San Antonio dedicated to biomedical imaging research.

Question: Does the VA intend to maintain its affiliations and sharing agreements?

Answer: VA fully intends to maintain both its affiliations with university medical centers and its sharing agreements with military installations.

Question: What steps can be taken to apply the San Antonio model of cooperation in other locales?

Answer: VA plans to utilize its national network capacity of E-mail, newsletters, satellite broadcasts, and conference calls for the publicizing of model sharing arrangements with military bases. VA encourages its facilities to emulate the successful San Antonio model for building mutually beneficial sharing partnerships.

Question: Lastly, I am concerned with the Administration's proposal that a service-connected veteran's employer must pay the veteran's employer premium contribution. Our nation has a commitment to care for service-connected veterans from appropriated funds. In today's tough business environment, health care benefits are considered a part of compensation. In this case, the service-connected veteran, not his or her employer, would be relieving the federal government of the cost of his or her care. Also, we need to encourage the employment of service-connected veterans, and this provision does not accomplish that.

Answer: The proposed policy is justified for a number of reasons. Under the President's plan we would no longer be defining eligibility and financing associated with VA health care as public policy unrelated to a national health care policy. Today, the majority of all service-connected veterans do not seek care at VA facilities and instead purchase private health insurance through their employer and use this coverage to obtain care from privately practicing hospitals and physicians. For these veterans, there will be little change in the employment based financing of their health insurance. The proposed policy is designed to introduce a comparable financing arrangement to the provision of VA health care. Under the proposed policy, VA medical centers would participate in an open market where all providers compete for enrollment and health alliance capitation financing derived from employment based contributions.

For certain start-up investments such as the community based outpatient clinics and facility "up-grading" projects described in your letter, funds appropriated by Congress will be needed. Appropriations will also be required to cover cost sharing fees and employee premium contributions that core eligible veterans (current Category A) would pay if they enrolled in a non-VA health plan but would not pay if they enrolled in a VA health plan. Finally, for core eligible veterans with Medicare eligibility who choose a VA health plan, and also for self-employed service-connected veterans, appropriations would substitute for cost sharing revenue and all premium payments, not just the 20% employee share.

Nevertheless, the viability of the VA health care system in the future would not be determined by appropriated funds under the President's plan. For the VA to succeed in competitive health care markets will necessarily require a sharpened focus on the customer. VA must enroll new customers and serve all customers well to insure their loyal patronage and the receipt of the alliance funding controlled by each veteran's choice.

As a final note, the President's plan for financing the care of service-connected veterans is consistent with promoting fair hiring practices for these citizens. Under the Clinton plan, service-connected veterans do not have to reveal their service-connected status to their employers.

If employers were exempted from paying the employer premium share, this would not be possible. Moreover, we want to promote employment decisions by private sector firms based on a veteran's expected productivity, not his service-connected status.